# The WIsper

*July 2004*

## *FROM THE PRESIDENT*

*Carl Eisenberg, MD, FAAP*

**Activities at the AAP Level**

The WIAAP was recently awarded an American Academy of Pediatrics 2003 Chapter Excellence Award. Our Chapter's involvement of so many members working on our 33 different committees was cited as a unique accomplishment.

Dr. Sharon Fleischfresser earned an AAP Special Achievement Award for her work with the Wisconsin EHDI / WE-TRAC programs. Dr. Jeff Lamont, WIAAP Secretary/Treasurer and Dr. Jeff Britton, Co-Chair of the WIAAP's Injury and Poison Prevention Committee attended the AAP's Legislative Conference in Washington, DC, in April.

**Activities at the District Level**

Dr. Halim Hennes, Chapter Vice President, Carolyn Evenstad, Chapter Executive Director, and I attended the District VI meeting in Richmond, VA, in April. District VI leaders met with other leaders from District IV. We received reports from Dr. Carden Johnston, AAP President, and from Dr. Joe Sanders, Jr., the retiring AAP Executive Director. We had a chance to meet the AAP's Vice President/President-Elect candidates: Drs. Robert Schwartz and Eileen Ouellette. We heard a presentation about national legislative issues and a physician-directed, Medicaid, managed care program in North Carolina and took an optional trip to Thomas Jefferson's home, Monticello.

**Activities at the Chapter Level**

Dr. LuAnn Moraski led a great 2004 WIAAP Annual Meeting held at the Kalahari Resort in Wisconsin Dells on Saturday, April 24th. Workshops on ADHD, Obesity, and Media were well received. Attendees are able to claim their CME credits on-line using PediaLink.

Dr. Karen Pletta was re-elected to the WIAAP's Board of Directors. Dr. Jeff Britton was elected to the WIAAP's Board of Directors to fill the open seat vacated by the retirement of Dr. Bill Perloff. Bill was thanked for his years of service to the Chapter. Dr. Perloff served as a member of the Board of Directors and as Co-chair of the Chapter's Emergency Medicine Committee.

All three By-law amendments were overwhelmingly approved by the membership.

The WIAAP's Access Committee's new Pediatric Council is beginning work under the leadership of Dr. John Meurer.

There will be a couple financial changes taking effect during the Chapter's next fiscal year which begins on July 1, 2004.

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## Wisconsin Chapter AAP Community Service Award

Steve Busalacchi, Director of Public Relations at the Wisconsin Medical Society was awarded the WIAAP Community Service Award by Dr. Carl Eisenberg at the recent Chapter Annual Meeting in Wisconsin Dells. Mr. Busalacchi has been involved in the CDC funded Wisconsin Antibiotic Resistance Network, the media task force of the Wisconsin Tobacco Control Board and has volunteered in a variety of community programs and projects as an advocate for children and children's healthcare.

## Pediatrician of the Year

**Timothy Corden, MD, FAAP**

Dr. Corden is shown receiving the Wisconsin Chapter AAP Pediatrician of the Year Award from Chapter President Dr. Carl Eisenberg at the Welcome Dinner prior to the Chapter's Annual Meeting .

Dr. Corden currently serves as Medical Director, Pediatric Critical Care Unit at the University of Wisconsin Children's Hospital in Madison. Co-Chair of the Chapter's Legislative Committee, Dr. Corden has provided written and oral testimony on behalf of the Chapter in a variety of legislative issues affecting children's health including child passenger safety, bicycle helmets, primary enforcement of seat belts, children's boxing, ADHD stimulant therapy, concealed weapons and others.

In 2002 Dr. Corden organized the first WI Chapter AAP Statewide Advocacy Conference involving residents from the three Wisconsin pediatric residency programs in discussions about child health issues with State legislators and their staffs.

At the national level, Dr. Corden is a member of the AAP Section on Critical Care, Section on Hospital Care, and Section on Injury Prevention. He is also the representative from the AAP to the JCAHO and represents the voice of children on that committee.

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**(President's Report Continued)**

Chapter dues will increase to $90 per year. Dr. Lamont, WIAAP Secretary/Treasurer, has developed a goal-driven budget that will allow the Chapter to maintain membership activities and services while slowly reversing the recent downward trend of our reserves.

There will be a nominal registration fee for those members attending next year's Annual Meeting on April 23, 2005. This nominal registration fee will include the cost of the lunch during the meeting. The separate charge for the lunch will be dropped. Non members will pay a higher registration fee.

Three of the Chapter's top-ten goals for the next fiscal year relate to obesity reduction. (See Dr. Sondike's article on page 8.) We are exploring different collaborations to bring resources into your hands.

There are significant issues to discuss with candidates for state and federal offices before the elections this year. Many of the candidates appear at summer festivals and parades. These are great times to focus on the needs of children. At the state level, what may happen to coverage for preventive, well-child visits if small businesses are permitted to negotiate for insurance plans that don't have to comply with state-mandated benefits? Are other children's services at risk if WI budget deficits persist? What about some of the WIAAP's other issues, e.g., mandatory bike helmets and primary enforcement of the seat-belt law? It would be very helpful if you took a minute or two to contact your State Representative and Senator during the campaign season to bring up children's issues. If you choose to become more involved, it's easy to help the candidate of your choice by writing letters of support to your friends, placing a yard sign, doing a literature drop, hosting a coffee, or contributing funds.

In keeping with the decision to hold one Executive Committee meeting each year at different sites around the state, the next meeting will be held in Wisconsin Rapids on Friday, Sept. 17, 2004. The featured discussion topic will be the future of the pediatric workforce. Any WIAAP member is welcome to attend Executive Committee meetings. If you are interested in attending, please contact Carolyn Evenstad, WIAAP ED at cmewcaap@aol.com or at the Chapter's office, 608-222-7751.

## Collaborative Effort To Combat Obesity Problem

One of the WIAAP's top ten goals this year is to address the obesity problem in WI children. Your WIAAP leaders have initiated a project related to this goal. The following is a brief description of what to expect.

As a result of a collaboration among the WIAAP, the WAPF, and WellPoint, WIAAP members in active practice will soon be receiving a packet of materials to help you combat obesity in your patient population. WellPoint, an insurance company, has developed and is donating a set of tools for your use. The packet will contain several patient brochures and a larger, reference document for your personal, desktop use. The WI Academy of Family Practice has developed a parallel process for its members, and Governor Doyle has made arrangements for even wider distribution of the material statewide.

We trust you will recognize this project as a demonstration of the way membership in the WIAAP can add value to your practice. Thank you for your membership.

Carl Eisenberg, MD, President WI Chapter AAP

## AAP District VI Chair Report

Kathryn Nichol, MD, FAAP

The Advisory Committee and Board of Director's meeting of the AAP occurred from May 18-23, and, as usual, it was a very meaty agenda. Following are some of the highlights.

**Electronic Health Records (EHR).** Dr. Joseph Schneider, a member of SCOCOT (Steering Committee on Clinical Information Technology) along with Board members, Dr. Ellen Buerk and Alan Kohrt led a discussion on EHR's. The topics discussed included:

Why EHRs now? What are the wants, needs and expectations of pediatricians regarding EHRs? How do the external marketplace dynamics of EHRs affect pediatricians?

Are EHRs the right thing to do? How they can help and hurt. What is the capacity and strategic position of AAP relative to EHRs?

What are potential next steps for the AAP?

After discussing the above, the BOD agreed with membership (EHR was the number one resolution at the last Forum) that EHRs are an important issue for the AAP to address and asked SCICIT to bring recommendations of "next steps" to the Board at its October meeting. Clearly, it is important that pediatricians be included in discussions on the development and implementation of the EHR, particularly the elements which are specific to the needs of pediatric patients (growth charts, immunization records etc.).

The BOD has been developing a draft of a policy for its relationships with industry and other organizations. Member dues contribute only 25% to the AAP budget. Significant monies are generated by Academy publications, but in order to accomplish our strategic priorities, support from industry and other organizations has been critical. Yet it is equally important that the AAP has clearly stated guidelines for our members and the world at large to see. I am delighted to report that the Board has approved a DRAFT of the policy. It will now be disseminated to the leaders of Chapters, Committees and Sections to get input from these three groups.

At the January 2004 AAP BOD meeting a presentation on the status of mental health issues was given, and the Board asked for a proposed plan to be offered at the May meeting. That was done with the following recommendations being made:

**INFRASTRUCTURE:**

*Create an AAP Mental Health Task Force

*Develop a clearinghouse on the AAP Web site that will include available resources

**EDUCATION/TRAINING:**

*Develop a mental health tool kit that will include material Re: how to screen, Dx and treat the 4-5 most common Mental health conditions

*Create a training to accompany the tool kit that will educate Pediatricians

*Create a screening tool or approach to assist pediatricians in evaluating the family's wellness

*Offer reimbursement and coding information following all mental health-related sessions presented at AAP meetings (national and chapter)

*Run a series of articles in "AAP News" focusing on mental health coding and reimbursement

**ADVOCACY:**

*Advocate for adequate reimbursement for mental health services provided by pediatricians and other mental health Providers

*Collaborate with other national organizations on children's mental health issues

*Design templates for chapter newsletters to assist with the advocacy process

*Provide technical assistance to the chapters

*Produce a chapter mental health resource guide

**PUBLIC EDUCATION:**

*Sponsor a marketing campaign to promote the benefits of a child receiving treatment from a pediatrician

*Develop and disseminate educational material to parents on the appropriate stages of child development, parenting methods, and where to seek help if mental health treatment is needed

*Create and disseminate educational materials providing talking points for parents and employers to ensure that mental health services are included in insurance plans

**EVALUTION:**

*Evaluate pediatricians comfort level in screening, diagnosing and treating children with mental health conditions. Repeat the survey in 3-5 years to evaluate the impact of the program

The BOD accepted the recommendations and will begin implementing them as appropriate.

The AAP has developed a Federal Advocacy Action Network (FAAN), which in January 2004 automatically enrolled all AAP members within e-mail address into the program. This brought approximately 35,000 new members into the program. The response from the membership has been wonderful as the FAAN has asked us to respond to various threats to existing legislation or entitlements, or to support legislation that would benefit children. Tracking the numbers from the MOC of the AAP website, approximately 4,500 letters have gone to the Hill since January.

**MEDICAID FUNDING:** When the Senate threatened to cut billions in Medicaid funding in their Budget Resolution, over 2,000 FAAN letters poured into Congress. The efforts helped secure votes to pass a Senate amendment that protected the funding cuts from happening.

**FAMILY OPPORTUNITY ACT** (Allows parents of children with special health care needs to purchase Medicaid): Senator Kennedy said letters from the Academy members helped the legislation pass the Senate.

**EMERGENCY MEDICAL SERVICES FOR CHILDREN (EMSC) PROGRAM:** This battle isn't over yet, but the hundreds of letters that have poured in is having an impact on trying to preserve the program for children.

If you have e-mail and aren't on the FAAN network, please sign up (go to the AAP website) and participate. It really seems to make a difference.

This is the time of year that those of us who live in the Midwest look forward to so much. Best wishes for a safe, healthy and wonderful summer and fall.

## *WI Chapter AAP Pediatrics Council Plans Meetings with Payers*

John Meurer, MD, FAAP

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

Pediatricians serving on the Council include Drs. Bernstein, Corden, DeMets, Dunigan, Eisenberg, Fleischfresser, Meurer, Meyer, Miller, Sunder, and Urban. Consultants to the Council include M Adams, R Gallagher, T Gazzana, A O'Connor, M Rakowski, and L Terranova. Beginning this summer, we plan to meet with the Governor's staff, State Medicaid and insurance managers, health plan directors, and healthcare collaborative and alliance leaders.

Priority topics for discussion with payers include:

Health insurance coverage, e.g., proposals for a universal insurance program

Health insurance benefits, e.g., exemptions in medication formularies, access to dental and mental health care, care coordination and nurse case management for children with special health care needs

Health care reimbursement, e.g., no or minimal co-pays for medications for chronic conditions, payment for counseling obesity and injury prevention, tobacco cessation, and ADHD treatment, adequate payment for new vaccines

Valid and reliable report cards related to quality, safety and cost of providers

If you are interested in joining our Pediatrics Council or would like to suggest topics for discussion with payers, contact Chair John Meurer at jmeurer@mcw.edu or 414-456-4116.

## WORLD BREASTFEEDING WEEK 2004:

### EXCLUSIVE BREASTFEEDING –THE GOLD STANDARD

**Safe, Sound, Sustainable**

Karen Pletta, MD, FAAP

World Breastfeeding Week is celebrated around the world by over 120 countries the first week of August (August 1-7, 2004). This year's theme is: "Exclusive Breastfeeding – The Gold Standard. Safe, Sound, Sustainable". In 2002, the WHO and Unicef launched the "Global Strategy for Infant and Young Child Feeding". This calls for all governments to "ensure that all health and relevant other sectors protect, promote and support exclusive breastfeeding for the first six months and continued breastfeeding for up to two years or beyond, while providing women access to the support that they require – in the family, the community and the workplace – to achieve this goal".

As pediatricians, we are aware that most families understand the benefits of breastfeeding, however sometimes there are barriers that limit their choice to breastfeed and/or to continue breastfeeding. The goal of WBW this year is to work towards the Global Strategy by reviewing why breastfeeding is safe, sound and sustainable both for mothers, communities and employers. It also addresses barriers women face and what communities, employers and health care worker can do to help families breastfeed. FYI, the articles and press will center on the following information as well as barriers and strategies for successful breastfeeding:

Exclusive breastfeeding is:

Safe: because it contains antibodies and protective factors to decrease many infections such as otitis media, diarrhea and pneumonia.

Sound: because human breastmilk provides a unique composition for human infants that provides needed nutrients and fluid. (Vitamin D supplement is recommended for babies after two months old).

Sustainable – because it is available as long as the baby's mother or a wet nurse is available. Mothers will make milk from any mixture of foods. There is no inconvenience or expense of preparing other foods or formula. The extra food cost for mom is small. Most mothers who return to work can continue to provide breastmilk by pumping if a room etc. is available by employers.

There will be many activities around the world and in local communities for World Breastfeeding Week 2004. Pediatricians can be helpful for their patients and communities by being involved in a variety of ways. E.g.:

Update knowledge and practical skills to provide leadership and support for local hospitals, clinics and patients.

Ask your local hospital about what breastfeeding support they provide -encourage offering the breast shortly after delivery, nurses experienced in helping with breastfeeding etc. Provide them with the information in "Ten Steps to Successful Breastfeeding" as needed.

Support mothers who are breastfeeding by providing positive reinforcement and help/referral as needed in the hospital and at clinic visits for as long as they continue breastfeeding, consistent with the "Global Strategy".

Participate in your local LLL World Breastfeeding Week walk. This walk is done around the world every World Breastfeeding week. It is sponsored by local LLL chapters to raise awareness of breastfeeding and support for breastfeeding issues.

Encourage your clinic, hospital and local businesses to provide a space for employees to pump so that mothers can continue to provide breastmilk for their babies while working.

There are many other activities and resources available for World Breastfeeding Week 2004. A free action folder is available at the World Alliance for Breastfeeding Action at: www.waba.org. This web site also reviews links/resources for health care providers such the "Evidence for the Ten Steps to Successful Breastfeeding", "Breastfeeding Women at Work", WHO breastfeeding training course materials, mother support groups etc. Further general information and specific information on a LLL walk in your area is available at: www.lalecheleague.org. If you would like to share other suggestions with WI AAP members for activities for WBW – please feel free to email WI AAP members at wiaap-net@lists.execpc.com.

## SUBSTANCE ABUSE SCREENING for TEENS

James Meyer, MD, FAAP

Substance abuse affects men and women of all ages including adolescents. Indeed use of a drug is associated with the top three causes of death of teens ages 15-19 years-accidents, homicide and suicide. Recently released data from the 2003 Youth Risk Behavior Survey summarizes this current pattern of drug use and is available for review in the May 21, 2004 edition of the MMWR or accessible on-line at www.cdc.gov/mmwr/preview/mmwrhtml/ss5302a1.htm.

To impact consequences to youth of substance use, the American Medical Association's Guidelines for Adolescent Preventive Services (GAPS) recommends that health care providers ask all adolescent patients about their drug use and risk taking. Pre-college visits, camp and sports evaluations at this time of year are a great opportunity to screen. With a non-judgmental approach with provision of confidentiality teens are remarkably honest.

A new, brief, drug use and risk screening tool for adolescents, CRAFFT has been developed by the Center for Adolescent Substance Abuse Research (CeASAR). Twoor more yes answers suggest a significant drug problem. This tool is being widely distributed for use and is part of many residency training programs as well as the American Academy of Pediatrics Bright Futures: Adolescent Case Studies.

When a problem behavior is identified use of brief office based interventions may help inform the teen that they may have a problem, educate them about safer health practices, motivate them to consider making a change in behavior and assist the teen in planning a solution to the problem drug use.

**CRAFFT**

**C-** Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

**R-** Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?

**A-** Do you ever use alcohol/drugs while you are by yourself, ALONE?

**F-** Do your family or FRIENDS ever tell you that you should cut down on your drinking /drug use?

**F-** Do you ever FORGET things that you did while using alcohol or drugs?

**T-** Have you gotten into TROUBLE while you were using alcohol or drugs?

—James Meyer, MD, Chair, Chapter Substance Abuse Committee

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## Allergist Outreach: Asthma Education for Primary Care Practices

### WAPF—Foundation Granted Renewal

John Meurer, MD, MBA, FAAP

Wisconsin Academy of Pediatrics Foundation recently was awarded a grant renewal from GlaxoSmithKline to expand the program Allergist Outreach Asthma Education for Primary Care Practices. The program aims to improve child asthma diagnosis and management by primary care practices serving children and families in Wisconsin and Minnesota.

It is a collaborative initiative of Wisconsin Academy of Pediatrics (Dr. Meurer) and Wisconsin Allergy Society (Drs. Mahr, Hermanoff, Kelly, Kooistra, and Zacharisen) in partnership with the Wisconsin Asthma Coalition and Fight Asthma Milwaukee Allies. The program is coordinated by Children's Health Alliance of Wisconsin and evaluated by the Medical College of Wisconsin Center for the Advancement of Urban Children.

Between April 2003 and March 2004, the five allergists and their nurses met with 107 physicians, nurses, and staff from 17 pediatric practices in Milwaukee, Madison, and LaCrosse areas. The 3-hour continuing education program included practice guideline review, clinical case discussion, equipment demonstration, and educational toolkit distribution.

The vast majority of participants evaluated the program as excellent. Surveys of participants before and after the program suggest self-reported improvement in prescribing daily anti-inflammatory control medication for persistent asthma, teaching written action plans to families, and working as physician-nurse teams. However, chart reviews before and after the program showed no change in documentation of asthma care. Thus we recommend use of a parent asthma questionnaire and medical record template to better document asthma history, exam, assessment, and plan to demonstrate appropriate care and to justify optimal reimbursement.

With continued grant support from GlaxoSmithKline as well as new, smaller grants from the CDC/Wisconsin Department of Health and Family Services, Novartis, Sepracor, and AstraZeneca, we plan to train 12 more allergist-nurse teams in Wisconsin and six Minnesota to offer the program. During the next year, these teams will reach out to an estimated 300 physicians and 100 nurses at 48 primary care practices in 10 Wisconsin metropolitan areas and southeast Minnesota to provide the continuing education program.

If your practice is interested in the program or you would like a copy of our questionnaire and template, contact project director John Meurer at jmeurer@mcw.edu or 414-456-4116.

# IMMUNIZATION and INFECTIOUS DISEASE NEWS

June 2004

Tom Saari, MD, FAAP

**Pertussis in Wisconsin:** Over 720 cases of pertussis were confirmed in Wisconsin during 2003. Fond Du Lac county led the pack with nearly 300 children and adults diagnosed and treated for this nationally resurgent disease. There was one infant death in our state and one adult death in neighboring Minnesota from pertussis. As of the end of May, 2004, we have had 273 pertussis cases confirmed statewide with Dane County showing the biggest increase and Racine County not far behind. As has happened before, outbreaks are starting in high school and middle school student groups and working their way down to infants and toddlers. Teenagers tend to have atypical symptoms and are often identified only though a pesky, persistent cough lasting 2 to 3 weeks.

The WCIP ( WI Council for Immunization Practices ) advisory group critically reviewed the circumstances leading to the extended outbreak of pertussis that occurred last year. Clearly, physician lack of familiarity with whooping cough presentations in older children coupled with their reluctance to test and positively identify index cases and carriers were major impediments to stopping the epidemic. The failure to treat household contacts and close acquaintances of cases led to three distinct waves of pertussis activity that could have been aborted much earlier if providers were tuned in to this disease and its management. Pertussis PCR testing of nasal swab specimens has revolutionized early detection of Bordella pertussis and is a tool we should all learn to use if we expect to avoid another year like 2003. Testing for suspect cases is absolutely crucial in epidemiologic control of whooping cough because a positive test will raise the prospect of patient contacts needing to be prophylaxed with a macrolide to break the cycle of spread. Many practitioners are reluctant to perform nasal swabbing because it might be unpleasant to the patient or they are unfamiliar with how to collect the specimen and where to send it. DHFS will be distributing another set of instructions to all Wisconsin practitioners that describes the testing procedure, its importance in case finding and directions for how to do the test and where to send it. Turn around time for results is a speedy 2 to 4 days, depending on when in the week the specimen is sent and the location of your clinic. If you are fairly suspicious your patient has pertussis or is a contact of a documented case, you should start a course of erythromycin ( 40 mg / Kg / day divided qid ) or azithromycin ( 10 mg / Kg once a day for 5 days staying at that dose level throughout ) at the time NP testing is done. If the pertussis PCR comes back negative, the antibiotic can be D/C'd

Sadly, we are already ahead of the pace of pertussis cases set at this time last year. DtaP vaccination protection does not last very long and many teens are vulnerable despite having received a full childhood 5 injection series. Even natural infection does not confer long term immunity so we cannot expect the vaccine to do any better. Once your have started antibiotics for a documented case or for a child you are strongly suspicious of having pertussis, please, please, please to not send the child back to school or daycare before a full 5 days of treatment. Physician permission given to a child to return to normal activities before 5 days of Rx has been determined to be responsible for propagation of pertussis in the community in more than a few situations.

**Pneumococcal Conjugate Vaccine Shortage**: Wyeth reports that PCV7 production and packaging has returned to levels that allow clinics to receive 100% of their prior allotments of vaccine that would normally allow full coverage of a practice's birth cohort. The sustainability of that level of production remains to be seen and for that reason the AAP and the CDC are still contemplating when we can return to a 4 dose schedule. A two stage ramp up is likely to occur beginning this summer but how fast we can return to normal is unknown. There is talk of creating a PCV7 stockpile to use as a reserve to smooth out any future disruptions in PCV7 supply before returning to a normal schedule.

Infants with underlying high risk health conditions should have been receiving their 4 dose regimen all along. Catch up with doses #3 and #4, once the green light is given, will most likely be directed only to those under 24 months of age who are behind on their regimen. It is anticipated that catch up recommendations will NOT be recommended for healthy kids who turned 2 years old or older who were short changed on PCV7 earlier. On the other hand, if you have excess vaccine, one can be sympathetic to giving a dose of PCV7 to a incompletely immunized child over age two years who falls into a intermediary category of risk ( recurrent ear infections, Native and African Americans, daycare attendees, etc. ). Similar to the strategy followed after our last PCV7 shortage, it is doubtful that a recommendation will be made to recall healthy children for their third and fourth PCV7 doses before their next scheduled well child visit. Hopefully you have been keeping a list of children who are behind and you can decide how aggressively to pursue them using your best judgment. Those of you on the WIR should have an easy time of it identifying those patients.

The DHFS Immunization Program is currently awash in PCV7 vaccine and should have no trouble keeping up with VFC orders this summer. If you used some of your own private stock PCV7 vaccine for VFC children, be sure to report that to the Immunization Program to get reimbursement in kind.

**Influenza and Children, 2004-05:** An analysis of the pediatric age group mortality trends during the 2003-04 Fujian flu season revealed 135 pediatric deaths with a mean age of 3 years old. 56% of the children who died had not received influenza vaccine, 13% were only partially immunized. 46% of the mortalities did not have known pre-existing high risk health conditions, 32% had underlying neurological or developmental disorders and a total of 39 deaths were associated with an encephalopathy. 27% of the children succumbed quickly and died while at home. On a whole, the 2003-04 seasonal mortality was only slightly higher than the average yearly influenza mortality of 92. The AAP and the CDC will place added emphasis on providing influenza vaccine to household contacts of all ages where children 0 to 23 months of age live. This is a bid to reduce hospitalizations in the youngest age groups and particularly in infants too young to immunize.

It appears that Wyeth and MedImmune have parted ways over their joint effort to market FluMist ( LAIV ) and MedImmune will go it alone. The latest information indicates that a limited amount ( 1.5 million doses ) of FluMist will be produced by MedImmune using the same influenza strains used in the 2004-05 inactivated injectable ( TIV ) vaccine. All indications are that it will be priced competitively with TIV and a more gradual strategy of introduction will be used to gain the confidence of practitioners.

**Autism and Vaccines:** The Institute of Medicine ( IOM ) report on Vaccines and Autism was published in May and concluded there was no credible evidence linking the MMR vaccine or vaccines containing thimerosal as a preservative and autism. This is good news for all of us to use as information when confronted with parents who remain concerned with the misinformation they are reading on some of the web sites critical of vaccines. The IOM also indicated there was no need for the CDC or the AAP to review or change their policies regarding recommendations that involve the few vaccines that still contain thimerosal ( influenza vaccine is the most notable example ). Neither the AAP nor the CDC will express any preference for the use of thimerosal free influenza vaccines for the new 6 to 23 month old cohort of healthy children or for pregnant women.

**New Vaccines on the Horizon:**

**Rotavirus:** There are now 3 rotavirus vaccine candidates that may emerge on the scene in the next two to three years. 1) Merck has a pentavalent bovine reassortant rotavirus vaccine called Rotateq in a huge phase 3 trial that now numbers over 60,000 infants ( most recipients are in the United States ). This trial is predicated on certain benchmarks for intussusception ( IS ) occurrence NOT occurring as the recruitment continues. To date, Rotateq has performed very well in preventing severe rotavirus disease and all indications so far is that it is not associated with the problems that had plagued the Wyeth Rotashield quadravalent rhesus reassortant product in 1998. 2) Rotashield was never decertified by the FDA and another vaccine company, BIOVIRx, has acquired its rights from Wyeth. It is believed their intention is to market it at some level including possible global distribution. BIOVIRx also contends that the numerous studies that set the IS rate in 2-3 month old infants receiving Rotashield at 1 in 10,000 doses is erroneously high and will try to convince us that the IS is no higher than baseline rates of unvaccinated infants. They have their work cut out for them. 3) a Glaxo SmithKline monovalent human live attenuated vaccine called Rotarix is undergoing large scale trials outside of the United States with the apparent intention of marketing their vaccine in the developing world where the fatality rate from rotavirus infection is 1 in 200 children. Depending on the adverse events experience ( including IS ) with that vaccine, it may be a candidate for an FDA application for this country a few years hence.

**Meningococcal Conjugate Vaccine:** Aventis will submit an application soon for FDA approval of their new quadravalent meningococcal **conjugate** vaccine ( MCV4 ) to be used initially in children 11 thru 19 years of age. This vaccine has performed very well in large clinical trials and promises superior immune responses compared to the currently available polysaccharide vaccine. Conjugate versions of polysaccharide ( PS ) vaccines produce anamnestic ( booster ) responses through T-cell induction that PS vaccines lack and can be expected to help eradicate nasal carriage of meningococci that PS vaccine fail to do. Unfortunately, MCV4 has not performed well in infants under a year of age which is a key group with a very high incidence of meningococcal invasive disease. MCV4, like PS, does not include the type B strain.

**Hepatitis A Vaccine Starting at 1 Year of Age:** Merck has been conducting Phase 3 clinical trials giving the current hepatitis A vaccine to children under 2 years of age. It has performed well in 1 to 2 year olds but not in younger patients because of maternal antibody interference in the very young. Expect a lowering of the recommended age for Hep A vaccine to 1 year of age.

**Wisconsin Pediatrician Immunization Surveys:** Many of you can anticipate receiving two Wisconsin pediatrician immunization opinion surveys early this fall. The first is a WIAAP sponsored statewide survey concerning the new AAP recommendations to give influenza vaccine to all healthy children 6 to 23 months of age AND household contacts of healthy children from birth through 23 months of age. It will assess your understanding of the rationale behind these recommendations and try to look at how much your 2004-05 influenza prevention efforts will be affected this fall compared to last year's wild ride. With the expected limited availability of the live attenuated intranasal influenza flu vaccine (LAIV ) for this coming year, we would also like to see what would prompt you to use it as an alternative choice of vaccine for your pediatric patients. The influenza survey tool is being developed under my direction by a second year UW-Madison pediatric resident, Dr. Nick Edwards. It will be distributed by the WIAAP under a separate mailing in September as a single page, postage paid questionnaire that will take only a minute to complete. This project continues a 12 year tradition by Wisconsin pediatricians in providing guidance to national policy makers by defining the limits of practitioner participation in new immunization schemes. ( See the impact of the last WIAAP survey supporting the re-introduction of another rotavirus vaccine ). So please join your colleagues in achieving a survey response rate to 100%. As always, I will provide you with the results of the survey in *The WIsper* when the number crunching is done.

A second survey will examine current hepatitis A vaccine immunization practices of Milwaukee County pediatricians and will be conducted by one of their colleagues, Dr. Svapna Sabnis. Although hepatitis A is recommended for all children over the age of 2 years who live in locales with high hepatitis A endemicity ( Milwaukee County and several Native American communities are thus designated in Wisconsin ), it is unclear how much this recommendation is being implemented. Dr. Sabnis has gained approval for her project proposal from the WIAAP and WCIP and is seeking IRB approval through MCW. This survey should provide state policy makers with important data when considering the advisability of a recommendation to extend hepatitis A protection to all the children in our state.

As always, I welcome your comments and questions on immunization matters:

Tom Saari, MD, FAAP tsaari@facstaff.wisc.edu

## *Obesity Epidemic Causing Disease Early in Life*

Stephen B. Sondike, MD

Overweight and obesity continues to increase in the American population, and is now reaching epidemic proportions. As much as 30% of American adults meet criteria for obesity, with Wisconsin having among the highest rates in the country. The National Health and Nutrition Examination Surveys III (NHANES III), when compared to previous NHANES surveys reveal that the number of children who are considered overweight or at risk has more than doubled in the last ten years, with an increasing number of youth falling in the higher percentiles. Not only are we getting heavier on average Young people with weight issues are not only at risk for long-term complications such as atherosclerosis and stroke, but are also developing disease early in life. Type 2 diabetes, fatty liver, Slipped Capital Femoral Epiphysis and sleep apnea are becoming more commonly seen in our younger populations.

The increase in NIDDM is the most disturbing, with as high as a ten-fold increase in recent years. In fact,, up to fifty percent of new pediatric diabetes diagnoses are now what used to be called "adult onset" diabetes. The early onset of insidious disease usually associated with older populations has led experts to speculate that our children's generation may be the first in centuries to have a lower life expectancy than that of their parents. Overweight kids also suffer fro m self-esteem issues, as bullying, teasing and bias are common, and adults suffer from bias in the workplace as well as in retail markets and social interactions.

The causes of this sudden increase is certainly multifactorial. Twin studies confirm that the development of obesity is largely genetic. However, the rapidity and magnitude of the recent increases are impossible to blame on genetics, and certainly the environment is implicated. The likely culprits are increases in portion sizes and an increase in consumption of sugary processed foods, and an increase in sedentary activity among our young people.

"Supersizing" has become rampant in our culture, but certainly the fast food industry is not the only culprit. In fact, serving sizes even in cook books have gotten larger, as recipes that used to serve six now serve four. The only place that serving sizes have not gotten larger is on food labels. Studies show that when presented with more foods, we will eat more. And now that we have 24 hour cartoon channels, armed wit commercials aimed directly at our children, there are more and more opportunities to sit and put on weight. Video games have also gotten more realistic and complex, leading children to prefer these activities to actual physical activity. Why go to the corner and play baseball when you can sit on your couch and BE Sammy Sosa?

In response to this increasing epidemic, our local, state and federal governments have responded by allowing schools to cut sports and physical education, providing soda and junk food heavy vending machines in our school, and failing to provide safe places to play. In fact, only two states in our union require physical education in schools (Illinois and Texas).

There are many ways to define obesity. The most common way is by calculating BMI (Kg/m2). The result can be plotted on a BMI growth chart found on the CDC web site (www.cdc.gov). Also on the CDC web site is a BMI calculator. Keep in mind that BMI may be limited by its inability to differentiate fat from lean body mass. Other methods include skinfold measurement, Bio-impedance, air displacement, and water submersion. In general , a child with a BMI above the $85^{th}$ percentile-for-age is considered at risk, and those above the $95^{th}$ percentile are considered overweight.

Although endogenous conditions occasionally cause obesity, these causes are rare. In general endocrine causes of overweight, such as hypothyroidism, Cushing's syndrome and Growth hormone deficiency result in short stature. Prader-Willi syndrome, besides it's particular features, usually is associated with a history of hypertonicity at birth. A girl with irregular menses and hirsutism might have polycystic ovarian syndrome (PCOS). In an otherwise normal appearing child, the recommended work-up will include fasting lipid profile, fasting insulin, glucose and liver function tests. Girls with suspected PCOSD should have an LH/FSH ratio, DHEAS and free testosterone. Only get a TSH if the patient is short or has had recent unexplained weight gain.

It is often assumed that intervention in the treatment of overweight is futile, but take a family centered focus aimed on making small, maintainable lifestyle changes can be helpful.

Turn off the XBOX (or TV or Netscape, etc.): Play baseball with your arms and legs, not with your thumbs. There is no replacement for getting outside and moving.

Walk or ride bicycles as a family activity. Try to do this at least three times per week.

Decrease sedentary activities in everyday life. Walk the stairs instead of taking the elevator. Get off the bus one stop early.

Decrease soda, juice and processed foods. Increase fruit and vegetable consumption. Replace low-fiber white breads with higher fiber wheat breads. Choose water as the beverage of choice.

Slow down eating habits. Put down the fork between bites.

Make healthy choices when eating out. Do not supersize.

Read food labels, and avoid products that contain "high fructose corn syrup" (this is sugar) or "partially hydrogenated" (these are trans fats- very unhealthy).

Shop the perimeter of the supermarket. Choose natural, whole foods.

If we focus on healthy eating behaviors and activities, rather than on diets and negative attitudes, I believe we can make a significant dent in the obesity epidemic in our children.

Stephen B. Sondike, MD, Program Director, NEW Kids Program, Department of Pediatric Gastroenterology, Medical College of Wisconsin

## Indications for the Use of Fluoride Varnish

Eileen M. Studders, D.M.D.

Dental caries is the most common infectious disease of childhood. The introduction of fluoride varnish (5% sodium fluoride/22,600 PPM) in the United States has lead to many studies proving a decrease in dental caries upon the biannual application of these varnishes. Fluoride varnish has also been shown to be effective in arresting early signs of dental decay (white spot lesions). However, case selection is key to using fluoride varnishes effectively. A thorough oral health risk assessment must be completed prior to the application of these varnishes. This risk assessment should include parental caries history, dietary habits, oral hygiene and medical history. Below is a listing of the indications and contraindications for the use of fluoride varnish.

Indications:

- Poor dietary habits
  - Nocturnal feeding of infants/toddlers with liquids other than water, including breast feeding
  - "Grazing" or sipping habits (snacking throughout day or using sippy cup or bottle with liquids other than water)
- History of carious lesions
- Current white spot lesions or stained pits and fissures
- Poor oral hygiene
  - Plaque or accretions on teeth
  - Lack of parental help/supervision when brushing
- Non-fluoridated community with no supplementation
- Family history of caries or gum disease
- Frequent use of oral or inhaled medicines which have a high sugar content
- Special medical needs

Contraindications:

- Low risk for development of dental caries and optimally fluoridated water
- Low risk and receive regular, routine dental care
- Ulcerative gingivitis and/or stomatitis
- Allergy to colophony or similar agents
- Systemic treatment

Although fluoride varnish can strengthen enamel, helping to prevent future caries and arrest early dental lesions by remineralizing enamel, they cannot reverse cavitated lesions or those that have reached the dento-enamel junction. Children with gross decay or early childhood caries would not benefit greatly from fluoride varnish application until after treatment of the existing decay by a dental professional.

With proper use and case selection, fluoride varnish application can aid in the reduction of new and recurrent dental caries in high-risk patients, and remineralize early dental carious lesions.

—Eileen M. Studders, D.M.D., Attending Pediatric Dentist, Children's Hospital of Wisconsin

References:

Autio-Gold JT, Courts F, Assessing the effect of fluoride varnish on early enamel carious lesions in the primary denitition. *J Am Demt Assoc.* 132(9):1247-53,2001

Bawden JW, Fluoride varnish: A useful new tool for public health dentistry. *J Public Health Dent 58:266-69, 1998*

*Fluoride Varnish Guide: Advantages, Application Protocol, Information for Caregivers*, State of Wisconsin Department of Health and Family Services Division of Health Care Financing

Primosch R, A report on the efficacy of fluoridated varnishes in dental caries prevention. *Clin Prev Dent* 7:12-22, 1985.

Vaikuntam J, Fluoride varnishes: Should we be using them? *Pediatr Dent* 22:513-16, 2000

**Wisconsin Society of Pediatric Dentistry Announces Program for Fall Meeting**

"Access to Dental Care:
A Collaborative Approach to
Prevent and Treat Early Childhood
Dental Problems"

September 11, 2004
Green Bay

For further information contact Brian D. Hodgson, DDS, Division of Pediatric Dentistry, Marquette University School of Dentistry. Office: 414-288-1566, Clinic: 414-288-7273

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Note: This conference relates to one of the Wisconsin Chapter AAP's top ten goals: Access to Dental Care.

## The ClearPath Program: Improving Access to Dental Care

Eileen M. Studders, D.M.D.

Children's Hospital of Wisconsin's (CHW) Dental Center has implemented a program, entitled the ClearPath Program, under the direction of A. Charles Post, D.D.S, to improve access to dental care for underserved children in southeastern Wisconsin.

Parents interested in the program attend a one-hour presentation on oral health and hygiene as well as the issues surrounding those insured by and who treat patients covered by Medicaid insurances. Open dialogues are encouraged throughout the presentation, and once completed, the parents' children will never have to wait more than 6 weeks for a dental appointment at our Downtown Dental Center, located in Milwaukee. The parents are assured that they and their children will be treated with respect, be involved in treatment planning, and always be treated by a dentist who is trained to treat children. This ClearPath Pass is valid as long as the patients attend all scheduled appointments, cancel in a timely manner if they cannot make an appointment and arrive to all appointments on time. (Continued Page 10)

**(ClearPath Program—Continued)**

The long-term goal of the program is to present data gathered about the ClearPath patients verses other Medicaid patients to dental professionals outside of CHW. Data will include show rates of those enrolled in the ClearPath plan, cancellations and how many of the patients were on time for their appointments. The purpose of this data analysis is to recruit community dentists to treat ClearPath Medicaid patients.

Current data shows decreased no-show rates and more advance cancellations for appointments made in the ClearPath group than in the control group. For example, current statistics for new patients include 114 patients from the ClearPath program (CPP) and 114 patients in the general pool of new Medicaid insured patients from the Children's Downtown Dental Center. Thirty-two percent of the control group patients no-showed for the first appointment, whereas only 7% of the CPP group broke their first appointment. There were no cancellations in the control group, but 4% cancelled from the CPP group and rescheduled their appointments. Smaller sample sizes were available for operative dentistry appointments, but of 63 CPP patients, only 6% no-showed for their first operative appointment, compared to 23% of 30 control group patients.

Continued data collection is needed to determine the long-term impact of the ClearPath program. However, initial data analysis shows positive clinical results and satisfaction among parents of the children in the program.

Questions or inquiries regarding the ClearPath program can be addressed to A. Charles Post, DDS at cpost@chw.org or Eileen Studders, DMD at estudders@chw.org.

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## Eye Exams for Kids

Jane Kivlin, MD, FAAP

Seeing well is important for functioning at any time of life and particularly for school as much of learning is visual. So why aren't eye exams for kids who can't see the blackboard covered by medical insurance? It is a business decision by many insurance companies to not provide coverage for refractive errors, or needing glasses to see well. Some plans offer "vision insurance" which will cover the examination and some or all of the cost of the glasses, usually for an extra premium.

Fortunately, if a child only needs glasses to see well, this is not serious disease. Refractions, the process of determining the correction to be put in the glasses, are performed by both optometrists (OD) and ophthalmologists (MD). There are often specials on these examinations offered by optical stores which are quite economical if paying out of pocket. However, the consumer needs to be aware that the main business of the store is to sell glasses and minor prescriptions can be given. If a child doesn't really need glasses to function and is asymptomatic, the glasses will be abandoned after the novelty wears off. Vision of 20/40, while not perfect, is compatible with good function in many settings, including an unrestricted driver's license. A child who squints to see things and is complaining, is noticing the decrease in vision and will probably be motivated to wear the glasses.

There are many medical eye problems in children, particularly amblyopia, which need a medical evaluation. It is not unusual for the insurance person processing the claim to mistake a medical eye evaluation as a refraction for glasses and reject the claim even though a medical diagnosis was listed. This is usually easily corrected with a phone call from the parents but the time consumption, with which we are all familiar, comes as a surprise. The child who failed a vision screening test but had a normal eye evaluation is often covered by insurance using 1) the rule out V71.8 (examination for a specific condition) and the 2) 368.0 (amblyopia) codes.

Visual acuity screening, seeing how each eye sees on the eye chart, is very effective at finding eye problems and is listed in the AAP's Periodicity Table. http:/appolicy.aappublications.org/cgi/content/full/pediatrics;105/3/645 (PEDIATRICS Vol. 105 No. 3 March 2000, pp. 645-646) The AAP clinical statement on eye examinations in children has specifics for each age group and referral guidelines. ( Pediatrics 111 (4) : 902-907). http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;111/4/902. If a school aged child can't see the board but can read a book, it is probably myopia or nearsightedness that can be treated with glasses. Decreased vision in a preschooler, particularly in only one eye, is more likely to be amblyopia.

Children who are too young to do an eye chart can be assessed by observing their visually guided behavior using each eye. Using one's smiling, talking face to get the child's attention, one can interrupt the line of sight of each eye separately and see if the child continues looking at one's face. If the child avoids the covering hand when one eye is covered, it implies decreased vision in the other eye. Equal objection to covering either eye relays a bit of useful information as well. A cover test, looking for strabismus, can be done simultaneously with checking visual function in this way. One has to make one's face more interesting than the covering hand or the child will look at the hand and seem to over converge because of looking so closely. In a recent observational study, it was found that intermittent esotropia of up to 12 degrees in a child less than 6 months old will often resolve spontaneously. Children over 6 months corrected age or with larger and constant deviations need to be evaluated..

—Jane Kivlin, MD, Pediatric Ophthalmology, Milwaukee

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***MISSION***

***"The Wisconsin Chapter American Academy of Pediatrics works 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."***

## WIAAP-NET

***Become A Subscriber***

****Free to Members***

****Update of WIAAP Activities***

The Chapter's e-mail distribution list, WIAAP-NET, currently has 233 subscribers. If you did NOT receive a message from WIAAP-NET dated 6/3/04 with the "TEST" in the subject line and believe you are a subscriber or would like to be a subscriber please contact me at 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. —Carl Eisenberg, MD

## Donald Burandt Memorial Lecture Wednesday, August 25, 2004

Presenter:
Mark Simms, MD, FAAP
Department of Developmental Pediatrics
Children's Hospital of Wisconsin

Lecture Topic:
"Attachment Disorders in Children:
Implications for Adopted and Foster Care Children

August 25, 2004
Beloit Memorial Hospital
8:00 AM—9:00 AM

1 hour CME credit

For further information regarding driving directions please contact Dr. Abraham Rodriguez, 608.364.2200 or e-mail at arodmd@hotmail.com

**CALENDAR**

**WIAAP - BOARD OF DIRECTORS**
**EXECUTIVE COMMITTEE**

**FRIDAY, SEPTEMBER 17, 2004**
**10:00 AM**
**The Ridges Golf Facility**
**Wisconsin Rapids, WI**

**WAPF—Foundation**
**BOARD OF DIRECTORS**
**Friday, September, 17, 2004**
**8:30 AM**
**The Ridges Golf Facility**
**Wisconsin Rapids, WI**

## *CHAPTER MEMBERSHIP*

Halim Hennes, MD, FAAP, Chapter Vice-President

*Dues*

The AAP has recently mailed the dues statements for 2004-2005 to all members. Please make sure that you check off and pay the chapter dues of $90.00 in addition to the national membership dues.

Member /Chapter News

Other membership news, 38% of Wisconsin voting members (552) voted at the last AAP presidential election. Within our District VI this was the highest percentage of returned ballots. In Georgia, District IV, 67% of the chapter members submitted their vote.

Last year we made a proposal to change *The WIsper* and offered advertisements to various hospitals and clinics across the state. Unfortunately, we did not get a favorable response and it was decided to place it on hold. However, we have made a commitment with the Children's Specialty Group from Milwaukee to place a quarter page add for them in three issue of the The WIsper and it was decided to honor that commitment.

Thank you all for your continued support of your Chapter and have a happy and safe summer

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Board of Directors
Executive Committee
Meetings:

2004

September 17, 2004
Wisconsin Rapids

2005

January 21, 2005
Madison

April 22, 2005
Wisconsin Dells

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