

The WIsper

November 2004

From The President

Carl Eisenberg, MD, FAAP

HAPPY BIRTHDAY WIAAP!

As far as we can tell, 2004 is the 60th anniversary of the WIAAP. Happy Birthday! Our Senior Committee, headed by Dr. Michael O'Halloran, is interested in a variety of projects including the preparation of a history of our Chapter and information about individuals and leaders from the past. If anyone would like to work on this project, please contact Carolyn Evenstad at cmew-caap@aol.com.

The WIAAP is continuing its effort to involve its members in activities which can lead to policy decisions. One approach to this involves surveys that seek member input. Two surveys are currently underway. One involves members attitudes toward the influenza vaccine recommendations, the other about their attitudes, beliefs and behaviors towards children's environmental health. If you receive one of these surveys, please respond.

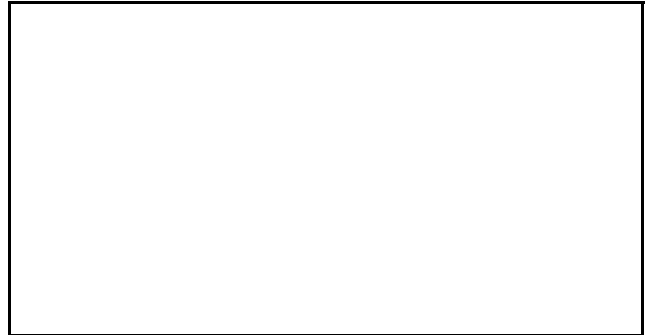
Members identified several issues of concern during our annual goal definition process. Your Chapter's leaders are actively working to help you and Wisconsin children by working on several fronts to address these issues.

Obesity, its prevention and treatment is one of these targeted problems. The WIAAP is partnering with the Blue Cross Blue Shield Foundation of Wisconsin to distribute two items to our members in active practice. The first is a guide for families, *The Healthy Habits for Healthy Kids*. You can expect to receive 75 of these guides. The second is a resource tool for physicians, the *Patient Counseling Guidelines for Families with Overweight Children and Adolescents: Prevention, Detection, Assessment and Management*. These items were reviewed by WIAAP members and some editorial changes were made before distribution. We hope you find these tools useful and would appreciate feedback. The Wisconsin Academy of Family Practice will also distribute these tools among its members. Governor Doyle also plans to distribute 500,000 of the *Healthy Habits for Healthy Kids guides*. The Chapter is also partnering in a grant application relating to encouraging physical activity. Beyond these activities, you may find this website of the Institute of Medicine of interest: <http://www.iom.edu/obesity/>

Access to oral health remains a problem for Wisconsin children. The WIAAP president has been named to Governor Doyle's Task Force to Improve Access to Oral Health. As you may already know, it is now possible to bill Medicaid when you apply dental varnish. Please visit the following website for more information about this program: <http://dhfs.wisconsin.gov/medicaid/updates/2004/2004-14.htm>

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Wisconsin Chapter AAP Joins Governor Doyle's Healthy Kids Initiative



Pictured above at the Governor's press conference on Wednesday October 13th are Carl Eisenberg, MD President of the WIAPP, Governor Jim Doyle and Cedror Aronow, MD President of the WAPF.

The press conference was held at Stevens Elementary School in Madison with 4th and 5th grade students in attendance. Governor Doyle announced his Healthy Kids Initiative to combat childhood obesity in the State of Wisconsin.

The Blue Cross Blue Shield of Wisconsin Foundation provided the funding to produce an instructional manual for primary care physicians to teach them how to evaluate obese pediatric age patients and how to counsel and motivate parents and children to reverse this process. There will be a half million pamphlets produced and distributed to these physicians to give to the parents to help them understand and follow through on eliminating the causes of obesity in their own children.

Since this Initiative is in line with the Chapter's goal of working on the problem of childhood obesity, the Foundation agreed to manage the funding of this project with the monies from the Blue Cross Blue Shield of Wisconsin Foundation.

In addition to Governor Doyle, Dr. Eisenberg and Dr. Aronow speaking at the press conference, the president of Blue Cross Blue Shield of Wisconsin Foundation, and Dr. Schwartzstein, President of the Wisconsin Academy of Family Practice also spoke regarding the project.

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From the President—continued

The WIAAP will have to address several political issues when the new Wisconsin Legislature convenes in January. Not the least of the issues will be the Taxpayers Bill of Rights, otherwise known as TABOR. We will all need to become educated about the various forms of TABOR. Here are some websites with relevant information that you might find interesting:

1. The first is from the National Conference of State Legislatures (NCSL).
<http://www.ncsl.org/programs/fiscal/taborpts.htm>
2. The second is from the Oregon Center for Public Policy
<http://www.ocpp.org/2004/issue040303.pdf>
3. The third is from the Denver Post
<http://www.denverpost.com/Stories/0,1413,36~53~2415522,00.html>

The Chapter's Nominating Committee is interested in learning of those interested in serving the Chapter as a member of the Board of Directors or as Secretary/Treasurer. Please contact Carolyn Evenstad at cmewcaap@aol.com if you want more information. The next meeting of the WIAAP's Executive Committee is scheduled for January 21-22 in Madison. If anyone would like to attend, please contact Carolyn Evenstad.

Please make plans now to attend the WIAAP's 2005 Annual Meeting to be held in the Wisconsin Dells at the Kalahari Resort on Saturday, April 23, 2005.

On the national level, the first Annual Leadership Forum (ALF) was held in Chicago the last weekend in August. The ALF brought together the leaders of AAP Sections, Committees, and Chapters. By all accounts, the meeting was a success. For the first time, Section and Committee leaders had direct and helpful input about Resolutions at Reference Committees. You are invited to submit any suggestions for resolutions to the WIAAP's Board of Directors at any time; forward your thoughts to Carolyn Evenstad.

Attendees at the recently completed National Convention and Exhibition (NCE) in San Francisco had a chance to hear from former First Lady, Rosalyn Carter, and earn CME credits in an exciting city. The AAP's 75th Anniversary will be celebrated at the 2005 NCE in Washington, DC, in early October. Please consider attending this event. There are a lot of 75th Anniversary commemorative items available including three special books and clothing items. In honor of this 75th Anniversary each Fellow of the AAP is urged to contribute \$75 to the Friends of Children's Fund. Right now, only 4% of AAP members contribute to this Fund. Since 1991, when the Board of Directors distributed the first Friends of Children Fund grant, more than \$3.5 million have supported important programs and activities. For more details about this fund, check out the following website: <http://www.aap.org/donate/fcannual.htm>

WIAAP Mission Statement

"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."

AAP District VI Chair Report

Kathryn Nichol, MD, FAAP

I just returned from the San Francisco NCE, and wanted to update you on the major issues discussed at the Board of Directors (BOD) meeting. San Francisco is a wonderful city to hold the AAP NCE meeting at. The weather was wonderful, the attendance was good. The responsibilities of members of the BOD prevents us from participating much in the scientific meetings, but I heard good things about the offerings.

Academy Industry Relations Guidelines

The BOD passed, depending on legal review, the Industry Relations documents. It has taken some time to develop this guideline on how the Academy will relate to industry and other organizations. The drafts have been reviewed and commented on by chapter, committee and section leadership. Many of the comments were helpful and were incorporated. Hopefully, legal consultation will give their stamp of approval, and it will be implemented in the near future. The Academy relationships with industry and other organizations document comes at an important time. Since only about 25% of our revenue comes from membership dues, while publications, journals and the CME and NCE account for another 53%, it is clear the Academy could not accomplish all it does without support from other sources. At the same time, it is critically important that that support not be perceived or actually influence our intellectual property. Hopefully, the guidelines developed in this document will serve the Academy well in this regard.

Electronic Health Record

It has become clear to the AAP leadership that the electronic health record (EHR) is an initiative that the federal government is promoting. It is seen as a safety issue to help reduce medical error. The Academy feels it is critical that there be pediatric input so that elements of a pediatric medical record that may be unique to the population we serve will be incorporated. A meeting to define and plan for the pediatric EHR was held in September by the AAP and the results and recommendations were reported to the BOD in Oct., 2004. A matrix was presented which included the current AAP and other pediatric activities and information, policy, advocacy/education and partnership categories. This was cross referenced with Pediatric EHR standards, Requirements for EHR system functionality, Development of the EHR system, EHR acquisition and implementation and EHR research. The participants of the meeting shared with the BOD what they felt were priority issues for immediate action, as well as an initial work plan. The report and recommendations were well received by the BOD. Expect follow-up on this item.

Task Force on Violence Recommendations

Violence is increasing in rural and suburban areas, and the decrease in urban areas seems to be reversing. In April of 2003, the AAP held a CDC funded Violence Prevention Symposium to examine the status of the 1999 Task Force on Violence recom-

mendations and determine how they should evolve. Recommendations were presented to the BOD in Oct. The two that were deemed most important to implement were:

*Develop and evaluate the Violence Intervention and Prevention Program (VIPP) for use in primary care and in emergency departments (VIPP-ED). The development of VIPP is nearly complete and is expected to be published in 2005. It is hoped that funding will be found to implement recommendations in about 25 practices to evaluate if the recommendations accomplish the stated goals.

*Develop a national agenda. Steps would include convening a national group of health and other organization (policy, public awareness, education, research, funding etc.), joining with other initiatives, and creating a national campaign. Funding is currently being sought to carry out this project.

Newborn Screening

Another topic discussed was the status of newborn screening (NBS). There are some areas of concern as regards newborn screening. While 51 states and the District of Columbia mandate newborn screening, only three disorders are universally screened for: Phenylketonuria, Congenital Hypothyroidism, and Galactosemia. Eight programs mandate two separate screens—one within the newborn period and the other at 2-4 weeks of age. One state program screens for three disorders, while other states screen for over 30. There are other disparities which include: family or guardian consent/dissent, fee for screening, storage procedures of samples, and location of the laboratory performing assessment. Fees assessed to families in order to obtain a NBS range from \$70 to no expense (in eight states). Dr. Steve Edwards has been the AAP's representative to the Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children under the Health Resources and Services Administration. Some of the issues discussed with recommendations include prioritizing diagnosing conditions that are treatable, considering cost-effectiveness, and developing recommendations as a guideline for every state. Some of the other questions are, where should the testing be done, particularly in those states with low numbers of newborns? What are the issues of follow-up, what is the incidence of false positives?

Academy Membership Issues

Membership issues in the AAP was also discussed. The Academy membership is becoming more diverse. There are three distinct age groups in the AAP, those under age 40, those from 41-55 and those over 55. They are relatively equal in numbers. More members are working part time. More of the membership is females. Many of our pediatric medical subspecialists and surgical specialists have other professional organizations competing with the AAP for membership. It is difficult to maintain academic pediatrician membership. We need to consider becoming more flexible in what we offer these diverse groups that will be of value to them. As the AAP tries to expand its membership, the Academy needs to look to the international arena as well as the minority pediatricians that either do not choose to join our organization or do not become actively involved. Again, we need to find what we need to do so these groups will find the AAP of value to them. Recommendations will be presented to the BOD in January.

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Growth and the Breastfed Infant

Karen Pletta, MD, FAAP, IBCLC

The issue of breastfed infants and expected growth may arise in pediatricians' offices as more mothers choose to breastfeed their babies per AAP recommendations. Some of these babies may not follow along the standard CDC growth charts. If the baby is otherwise healthy with no clear medical problems, the question then arises whether the baby is receiving enough calories. Suggestions that the baby may need more calories can make mothers feel pressure to stop/supplement breastfeeding. However, proper nutrition and adequate calories are obviously important for growth and development.

The newer CDC growth charts from May 30, 2000 are a reflection of combination of breastfed and formula fed infants and are recommended as the standard growth chart for healthy children in the U.S (cdc.gov/growthcharts). The CDC notes on their website that "In general, exclusively breast-fed infants tend to gain weight more rapidly in the first 2-3 months. From 6-12 months breast-fed infants tend to weigh less than formula fed infants." (cdc.gov/growthcharts/growthchartsFAQ). A study from the World Health Organization (WHO) found that breastfed babies who were exclusively breastfed for the first 4 months of life and breastfed for at least 12 months seemed to grow at faster rate for the first 2-3 months then at a slower rate for 3-12 months over the first 12 months of life when plotted against the currently available CDC growth charts. (de Onis and Onyango, "The Centers for Disease Control and Prevention 2000 Growth Charts and the Growth of

(Continued next column)

District Chair Report—continued

Quality Initiatives

There was a very exciting presentation on quality. Quality has been one of the AAP's strategic priorities for some time. However, the same amount of resources has not been allocated to quality as has been devoted to access and reimbursement. There are a number of initiatives that have been developed to improve quality of care provided to children. They include pedialink, eQIPP, work on development of the electronic health record, a taxonomy for the development of evidence based guidelines, a template for moving from guideline to practice change, built on the successful ADHD program, involvement of chapters as indicated by the enthusiastic response to the Partnership for Quality effort, and the Quality in Pediatric Subspecialty Care. My sense is that more resources will be spent in the future on developing a more robust quality initiative within the Academy.

As I look back on the issues addressed at the recent BOD meeting, it seems once again it was very productive and forward looking.

My next newsletter will occur after the January BOD meeting. So, I'd like to wish all of you a very blessed holiday season, and peace, mostly peace in this world. Kathy Nichol

Breastfed Infants". *Acta Paediatr* 2003; 92:413-419. Stockholm.ISSN 0803-5253). They reached this conclusion after evaluating a pooled sample of 226 healthy breastfed infants from North America and Europe via data collected from "WHO Working Group on Infant Growth: An evaluation of infant growth." Geneva: World Health Organization;1994 (WHO/NUT/94.8). The 1994 report noted that the breastfed data set did not follow consistently with current WHO references and recommended further study for infants through 5 years old.

Although studies to confirm this growth pattern for breastfed infant growth are underway, the 1994 WHO breastfed charts may be helpful for the pediatrician to review and are available on the internet so that parents may be aware of the study and raise this for discussion. I recently had a discussion of this issue with Dr. Deborah Frank, a professor of pediatrics at Boston Medical Center, who has published on breastfeeding and growth and is director of the Pediatric Growth Clinic at Boston Medical Center. She reviewed that other studies seem to be confirming these growth rate differences for the first 12 months of life for breastfed infants. She felt that these children > 12 months old then seemed to follow CDC % or at least have relatively consistent weight/height ratios. She also reviewed that it is WHO standard that weight/height ratio <10% = "at risk for malnutrition" so that weight/height ratio should be >10% regardless of age.

Therefore, in the office, if a breastfed baby seems to be having normal eating pattern and is otherwise healthy but not following the CDC growth curves, it may be helpful to compare growth on the 1994 WHO curves. If the baby is following the 1994 WHO curves and having a stable weight/height ratio >10%, then higher calories/supplementation may not be necessary. Follow-up should be done to ensure stable weight/height ratio and rate of gain at least on WHO curves through 12 months. Beyond 12 months, Dr. Frank felt that most babies do follow along the CDC curves or have stable weight/height ratios >10%. The ongoing WHO research for breastfed infants and growth up to 5 years old will be helpful in the future.

The WHO weight/height charts for breastfed boys/girls 0-12 months old can be found at "An evaluation of infant growth: a summary of analyses performed in preparation for the Expert Committee on Physical status: the use and interpretation of anthropometry". Doc WHO/NUT/94.8 Geneva: World Health Organization, 1994,pg 59-66. It may also be helpful to directly access the charts via other websites: 1) cdc.gov/nccdphp/dnpa/growthcharts/training/modules/module2/text/page5h.htm – review and WHO data plotted on CDC weight/length chart for girls. 1) www.promom.org/bf_info/growth.html – WHO breastfed weight/height charts for the first 12 months of life for boys/girls, 2) www.kellymom.com/babyconcerns/growthcharts.html – plot of WHO data onto CDC charts weight/age for boys/girls, WHO breastfed weight/age charts boys/girls, discussion of breastfeeding/expected gain. The site does review that weight/height ratios should be stable and that the data is preliminary.

I hope that this information is helpful for your practices. Please feel free to email me with other breastfeeding issues that would be helpful to review at: karen.pletta@uwmf.wisc.edu.

Pros Update

Abraham Rodriguez, MD, FAAP

To join many other pediatricians contributing to innovative findings, contact arodmd@hotmail.com or call 608 364 2316.

Based on Febrile Infant Study

Practitioners followed current guidelines in 42% of episodes. They hospitalized 309 fewer infants younger than 1 month of age and conducted fewer diagnostic tests than they would have had they followed current guidelines. Neither current guidelines nor the model developed in this study performed with greater accuracy than observed practitioner management.

- Of the 3066 infants seen during a recent national pediatric study, 1975 (64%) were managed exclusively outside the hospital. A single visit was recorded for 909 infants, while 761 infants had 2 or more visits and 305 had 3 or more visits to the hospital. The low frequency of hospitalization may be attributable to multiple office visits and/or telephone contacts.
- Bacteremia was detected in 1.8% of infants (2.4% of those tested) and bacterial meningitis in 0.5%. Despite lack of adherence to guidelines, PROS clinicians detected as many cases of bacteremia/bacterial meningitis while performing fewer tests and hospitalizing fewer infants than would have occurred if strictly adhering to practice parameters.

The findings suggest that if close follow-up care is attainable, the management of selected cases by experienced clinicians using clinical judgment may be an appropriate alternative to strict adherence to published recommendations, with the potential benefit of reducing considerable costs and iatrogenic morbidity.

The following article based on study results recently appeared in *The Journal of the American Medical Association*:

[Pantell RH, Newman TB, Bernzweig J, Bergman DA, Takayama JI, Segal M, Finch SA, Wasserman RC. Management and outcomes of care of fever in early infancy. JAMA 2004; 291: 1203-1212.](#)

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Pathways Foundation Offers Brochure

“Assure the Best for your Baby’s Physical Development”

Pathways Awareness Foundation, a national non-profit organization dedicated to raising community awareness of the benefits of early detection and early therapy for children with physical differences, received an endorsement from the American Academy of Pediatrics for their brochure “Assure the Best for your Baby’s Physical Development”.

The brochure, designed to educate parents and assist medical professionals, includes a growth and development chart highlighting speech, play and physical developmental milestones from 3 to 15 months of age. This unique tool allows parents to become proactive in tracking their child’s development and encourages early treatment for delays.

To receive your free copies of the brochure to distribute to parents or to get more information call their “parent-answered” toll-free number at 1-800-955-2445, email at friends@pathwaysawareness.org or visit their web-site at <http://www.pathwaysawareness.org/>

Pathways believes early detection is the best prevention.

IMMUNIZATION and INFECTIOUS DISEASE NEWS

November ,2004
Tom Saari, MD, FAAP

Pertussis in Wisconsin: As of November 2, 3449 cases of pertussis have been identified in Wisconsin with every county in the state reporting at least one case. Most cases have been identified in the southern health districts with Milwaukee Co. leading with 497 confirmed cases, Dane Co. next with 470 and Waukesha and Washington Cos with 341 and 253 cases each. This represents a 5 fold increase over the total cases for 2003. 75% of the cases have been confirmed by PCR from nasal secretions, 7% by culture or DFA and 18% by clinical criteria. Wisconsin remains #2 in the country (behind North Dakota) for the most number of cases per 100,000 population (66). No deaths so far but the number of pertussis hospitalizations have doubled indicating that the big increase in cases is more than a matter of increased awareness with increased testing. Pertussis naturally fluctuates in incidence over 4 to 5 year cycles but this year has been unusually extreme. All pediatric age groups are affected with adolescent disease activity showing a strong secondary peak consistent with the pattern seen over the past 10 years. Even more worrisome is that the winter months are the peak periods of pertussis activity. This coincides with influenza and RSV season which complicate the clinical assessment process because most pertussis is modified disease in partially immunized younger children and fully immunized preteens and adolescents. The catarrhal phase of pertussis (and most infectious period) looks like the common cold lasting for days before a cough sets in. Without a high index of suspicion, the child with pertussis may have several days of intense exposure to others before the parents seek medical attention and health care providers zero in on the pertussis diagnosis.

Schools and public health nurses have been instructed to do aggressive case finding by the State Health Department using case definitions like a cough for more than 7 days, a night time cough, a cough not responding to cough medicine and a child or adult who works or attends a school where there are known pertussis cases. Such broad definitions have created havoc for pediatrician's offices where dozens of phone calls are received daily from parents who have been told by the school or the public health nurse to seek medical attention; ie. get a PCR, get started on antibiotics and remain isolated for 5 days while on meds.

The guidelines we have all received from Dr. Jeff Davis and the State Health Department are well conceived as a necessary evil to blunt this epidemic. The categorization of pertussis cases as Clinical, Confirmed, Probable and Suspect are reasonably defined so that practitioners can use their clinical judgment to determine the status of the patient they are examining. Unfortunately, at this time of the year, separating out the patient with viral disease from those with pertussis on clinical grounds or by history is a terrific challenge. It is better, however, to error on the side of testing the patient and starting them on treatment. If the patient had not received previous antibiotics and the PCR is negative when done within the first 7 days of cough, pertussis can be ruled out and any subsequent treatment discontinued. In this scenario, any negative PCR obtained 8 days or more after the onset of the cough is of questionable reli-

ability but because of the duration of symptoms, the patient is considered noninfectious and only the contacts of this patient need to be assessed. Patients who present for evaluation with symptoms consistent with pertussis (but less than 8 days of cough) who have been on antibiotics for 4 days or less when the PCR is performed can be considered negative for pertussis if the PCR is negative. These same patients who receive more than 4 days of prior antibiotics makes the reliability of a negative PCR questionable. If their clinical course subsequently meets the case definition, these patients can be considered "probable" cases and treated as such. If they are linked to a known documented case, then they are considered a confirmed case of pertussis with a negative PCR.

Most problems for the pediatrician arise when patients are referred to the office as a "contact" or "close contact" by the public health nurse or the school system and the clinical details of the type and degree of exposure are lacking. The "Contact" patient is usually asymptomatic and the quandary is whether to treat or not based on the degree of exposure that might have occurred. Unfortunately, this part of the history is often missing and the parent doesn't know the nature of the contact, only that a possible case was somewhere in the school or daycare but is the definition of "close contact" met? Face-to-face contact; shared oral, respiratory or nasal secretion contact with an symptomatic index case is one thing, being in the general vicinity of an index case is another. Was the index case sitting in a desk next to the patient, across the room, in another class room or in the gym? These details can be crucial in making clinical decisions about testing and treating asymptomatic "contacts". Asymptomatic contacts can be treated but may not need to be isolated until they become symptomatic. This nuance is sometimes lost on the public health nurse who may insist on the contact patient without symptoms staying home from school. To help with improving the flow of information between referring public health staff and the treating pediatrician, the Health Department is working with WCIP to create an instrument to be filled out by the school health and public health nurses that provides more clinical detail about the nature of exposures to allow the child's physician to determine if testing and antibiotic management meets the published state criteria. Physician concern about the overuse of antibiotics, especially macrolides, needs to be appreciated when patient referrals don't meet the case definitions.

Please go to dhfs.wisconsin.gov/immunization to look up all the details on the Wisconsin pertussis control program.

Influenza and Children, 2004-05: There have been five influenza isolates in Wisconsin so far. All have been Type A and they appear to be an H3/N2. It is unknown what specific strain they are or what kind of match they would be to the current vaccine. The State of Wisconsin Health Department has been conducting weekly conference calls to discuss the priority system, vaccine supplies and vaccine distribution. This time around, it is being left up to the local health departments to arrange for vaccine redistribution within their area. There will be no attempt to run a state-based clearing house for vaccine redistribution like what was tried in previous years of shortages. It appears Wisconsin will have just enough vaccine to cover the high risk categories that are contained in the Governor's Emergency Order if everything plays out properly. Although the eld-

erly > 65 years of age represent 58% of the demand for vaccine under the new priority system, pediatric needs are contained in 6 of the 8 priority areas. I will comment here on questions you have raised the past month about who should get vaccine in these categories:

1) Children 6 to 23 months of age are considered as of equal importance in receiving flu vaccine as adults over 65 and any of the other priority groups. These children make up 5% of the total individuals listed in the 8 priority groups but represent the greatest reservoir of virus for spread throughout the community. Pediatric formulated influenza vaccine (0.25 ml) without thimerosal should be reserved only for those under 36 months of age and not used for older children or adults. Neither the AAP nor the CDC have expressed a preference for the use of thimerosal free versus flu vaccine using thimerosal as a preservative for use in children 6 months old or older. Children who require 2 doses of influenza vaccine should get the first dose ASAP but do not place their second dose in reserve. Continue to vaccinate all those in the priority categories on a first-come, first-served basis and if there is enough vaccine available when the child's second dose is due a month later, then give it. A single dose will provide some protection against one or more of the three strains in the vaccine and exposure to the wild virus during the influenza season may serve as the second dose resulting in lesser disease severity. Those receiving only one dose this year will only need a single dose of vaccine next flu season.

2) Children over 6 months of age with chronic heart and pulmonary conditions should only receive Trivalent Inactivated Vaccine (TIV). Live Attenuated Influenza Vaccine (LAIV) is not approved for these children. Under the Emergency Order, household contacts of these medically high risk patients are NOT candidates for TIV or LAIV. However, I anticipate LAIV to be removed from this restriction in mid November so it may be given to healthy household adult and child contacts (> 5 years of age) of these high risk children. The only restriction pertaining to LAIV use in contacts of high risk patients are if those patients are severely immunocompromised and require protective isolation. Keep in mind that premature infants are considered medically high risk on two counts and particularly vulnerable to influenza morbidity and mortality.

3) Pregnant women are not children but they pose a risk to their unborn fetuses if they contract influenza anytime during pregnancy (premature birth, stillborn). Remember that if a pregnant mom is not given flu vaccine during pregnancy, she should receive the vaccine in the immediate postpartum period because of her risk of passing influenza virus to her newborn infant during the first 6 months. Neither TIV nor LAIV is contraindicated in the breast feeding mother but LAIV is not approved for use during pregnancy. Thimerosal containing vaccine is perfectly safe to give to a mother in any stage of her pregnancy.

4) Children > 6 months of life who have medical conditions like diabetes, kidney disease, blood and metabolic disorders and Immunosuppressed states like HIV that require regular medical follow up are candidates for TIV.

5) Children who take ASA on a regular basis to reduce their chances of developing Reyes syndrome it contracting influenza. Only TIV is approved in these children.

6) Household contacts and out-of-home caregivers of children less than 6 months of life should receive TIV or (if age appropriate) LAIV. Household contact can be defined as children > 23 months of age and adult caretakers living at the residence who have extended contact with these infants in the course of a week. Transient and infrequent visitation to the household by asymptomatic non-care-givers does not constitute a reason to vaccinate such visitors. Symptomatic persons should simply stay away. With the production of LAIV expected to top 3 million doses this year, LAIV use in qualified household contacts will allow stretching of TIV supplies for those who can only use TIV. This also holds true for use of LAIV in healthy health care workers who have direct patient contact (like your office staff). LAIV is selling for \$16 / dose non-returnable and \$23 / dose in the returnable form.

Influenza Vaccine Practice Survey: We received over 130 responses to the survey many of you were sent in September. Fortunately, most of you filled out your survey before the announcement of the influenza vaccine shortage, thus the results should not be influenced by the latest supply snafu. Hopefully, the survey will accurately reflect your thinking about the childhood influenza prevention recommendations and will allow policy makers to develop strategies for provider education about vaccine applications in children. The survey numbers are being analyzed and should be available to you in the next *The Wisper*.

Meningococcal Conjugate Vaccine: The FDA Advisory Panel has given its approval of the quadrivalent (A,C, Y, W 135) conjugated vaccine as a preliminary step to full FDA approval expected toward the end of 2004 or early 2005. ACIP and the AAP-COVID will wait until then before making specific recommendations for who should receive the vaccine and whether a "routine use" recommendation is made versus a "at provider discretion" recommendation. The two groups of pediatric patients receiving the most consideration are those 17 to 18 year olds who would be off to college and all 11 to 12 year olds in middle school. Inclusion of the middle school children is tempered by the lack of sufficient antibody durability data beyond the three years the vaccine trials have been going on and whether these children would be protected 6 to 7 years later when they are off to college without needing a booster. Logic says that a single dose of this conjugated vaccine should be adequate to provide that length of protection, but..... It doesn't appear the economics of this vaccine (if the price remains in the \$70-80 range) would support a "catch up" recommendation for those children between these two groups any time in the near future.

Of interest is the expected marketing in the United States of a meningococcal C conjugate vaccine from Britain for use in infants under a year of age where the highest incidence of invasive meningococcal disease occurs. The current formulation of the quadrivalent conjugate has not performed well in this age group so it is possible we might be using two different meningococcal conjugate vaccines in our patients at different stages of their lives.

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

Wisconsin Pediatrics Resident Advocacy Day 2004

Amanda Brandow, DO; Dan Dorrington, MD;
Krista Wiger, MD; Earnestine Willis, MD, MPH

The **Third Annual Wisconsin Pediatric Advocacy Day** was held Monday, Oct. 4, 2004 in the Children's Hospital Auditorium and Medical College of Wisconsin-Health Research Center. This is the first year the Medical College of Wisconsin's Department of Pediatrics has hosted the event in collaboration with Children's Hospital of Wisconsin and the Wisconsin Chapter of the American Academy of Pediatrics. Events were scheduled from 8 a.m. to 3 p.m.

This conference brought together pediatric residents, medicine/pediatric residents and medical students from across Wisconsin to learn about child advocacy, to showcase pediatric residents' community-based child advocacy initiatives and to have a dialogue with key public policy experts highlighting legislative processes. Representatives from all pediatric training programs participated: Marshfield Clinic - 4 residents; Medical College of Wisconsin - 18 residents (including 4 medicine/pediatric residents) and University of Wisconsin - 13 residents. In addition, this year the residents offered voter registration with the support of the League of Women Voters. Voter registration onsite resulted in 33 professionals registering to vote throughout the day's activities. Several of MCW faculty, UW-Madison faculty, officials of the Department of Health and Family Services and staff joined in on the activities for the entire day.

The keynote speaker was State Senator Theodore J. Kanavas (Rep. - Brookfield), who spoke on *Medicine and Politics: The Whole Picture* as it impacts children's health and the health of everyone in this State. He shared his perspectives on health care in Wisconsin and emphasizes the critical process in State government to be attentive to the Organization Committee that controls the agenda and the Joint Finance Committee that appropriates billions of dollars each year. A very engaging discussion allowed us to start the day.

Following a lively discussion we discovered that residents are engaging in a wealth of exciting Advocacy Initiatives. Pediatric residents from across the State presented the following Initiatives.

Marshfield Clinic – *TARWAR* Pediatric residents utilize the tobacco-free education program of the American Academy of Family Physicians in area classrooms.

Medical College of Wisconsin- *WI Needs A Boost* Advocacy project that galvanized a letter writing campaign from pediatric residents to their legislative representatives urging them to support an assembly bill that requires 4-7 year olds to sit in a booster seat.

UW Madison – *P.R.I.D.E.* A collaboration between middle schools in Madison and Madison pediatric residents where teachers nominate a student who is exceptional outside the classroom. Pediatric residents select, with the teacher's assistance, an

outstanding student for community services and present that student with an award.

UW Madison – *Think First* A pediatric resident program that educates 2nd -3rd graders by teaching them injury prevention.

UW Madison – *Heads Up* A pediatric resident program that provides education and free bicycle helmets to patients at the community hospital emergency department.

The afternoon Breakout Sessions consisted of:

Legislative Process: Mark Grapentine, JD and Jeremy Levin from the Wisconsin Medical Society discussed how pediatric residents can get involved with the legislative process;

Handling the Media as a Pediatrician: LuAnn Moraski, DO from the Medical College of Wisconsin offered pediatric residents concrete examples to effectively deal with the media;

Urban Health, County's Role in Coordination of Health Service: Chairman Lee Holloway and Rob Henken from Milwaukee County discussed the county's role in managing medical assistance, especially GAMP, to underserved populations; and

Health Partnerships for Children: Bevan Baker, City of Milwaukee Health Commissioner briefly discussed how to partner and how each person's profession is linked to public health.

Overall comments from the sessions were very favorable and can be summarized in the following comments:

"The day definitely interested me and energized me for advocacy."

"Great to hear about other resident's advocacy projects."

"Hadn't thought about energizing my advocacy skills."

"Great explanation of how the government will affect our careers."

"We need to become active in government."

NIH INTERNET ENCOPRESIS STUDY

Encopresis is estimated to affect more than 2 million children. Researchers at the University of Virginia have developed an intervention incorporating behavioral treatment and education with medical management. It has been found to be effective in clinical settings, and was recently transformed into an Internet intervention. The program has undergone successful pilot testing, and a national trial of this program is underway. Physicians who treat pediatric encopresis are needed to be a part of this NIH treatment outcome study. Physicians will continue to treat their patients, but half will be randomized to also receive access to our web program. Both patients and physician offices will be financially compensated.

To qualify, physicians must see at least four primary encopretic children between the ages of 6 to 12 each year. If you are interested in learning more, please call (434) 924-8020 or toll free at (800) 251-3627 (ext. 48020) or e-mail study@ucanpooptoo.com. HIC #11116.

2005 Annual Meeting April 23, 2005 Kalahari Resort, WI Dells

The WIAAP Annual Meeting will be held on Saturday, April 23rd, 2005 at the Kalahari Resort in Wisconsin Dells. The one day CME program is free and will consist of a variety of speakers focusing on common issues in the practice of general pediatrics. Some of the topics will include assessing and maintaining good dental health in children, postpartum depression and the pediatrician's role, environmental mediators of obesity, cancer and other childhood diseases, and bioterrorism/terrorism responsiveness from a pediatrician's perspective. The program and enrollment information will be mailed in January. Please mark your calendars. We look forward to seeing you there. Lorelle Manion, MD, FAAP, Annual Meeting Chair

Chapter E-Mail Distribution List Update

The Chapter's e-mail distribution list, WIAAP-NET, currently has 239 subscribers. If you did NOT receive a message from WIAAP-NET dated 10/17/04 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.

SOFTWARE FOR YOUR PDA

Carl Eisenberg, MD, FAAP, Member, SCOCIT

There are a lot of medical programs available for your personal digital assistant. Here are some web sites you might visit to check out offerings: Pediatrics On Hand: <http://www.pedsonhand.com/> and PedsPalm.Com: <http://www.pedspalm.com/>. There is a handy, free medical calculator program available for those with Palm devices at <http://medcalc.med-ia.net/desc.html>. The AAP makes some of its publications available in a PDA format (e.g., *The Red Book, Grand Rounds*). These are available via the AAP's Bookstore (www.aap.org) and make use of High Wire Press (<http://highwire.stanford.edu/>) to get the materials onto your PDA. You might also check out Skyscape at <http://www.skyscape.com/index/home.aspx> for commercial medical software products.

Call For Nominations

Openings: Two Board Members at Large Secretary/Treasurer

There are two positions open on the WIAAP Board of Directors. The responsibilities of a Board member at large includes attending three Executive Committee meetings held each year, participation in email discussions of issues between meetings, and voting as required, either in person or via email. The Board votes on Chapter policies, endorsements and financial issues.

The term of office for members at large to the Board of Directors is three years. Members at large may serve two consecutive three year terms. After serving two terms there must be a hiatus of at least one year before a member may be re-elected to the Board of Directors.

The Secretary/Treasurer position is the entry level in the officer pathway. Once elected to the position of Secretary/Treasurer the individual will move to the Vice Presidency and then on to the Presidency. (There is no election for Vice-President or President.) The Secretary/Treasurer position provides a great basis for understanding the inner workings of the Chapter. Financial services including bookkeeping and accounting are contracted out to the Wisconsin Medical Society.

Nominees must be Fellows of the American Academy of Pediatrics and paid members of the Wisconsin Chapter.

Please contact Joanne Selkurt, MD, FAAP, (jselkurt@trivest.net), Nominating Committee Chair, with any nominations, or Carolyn Evenstad at the Chapter office (cmewcaap@aol.com) for further information.

Deadline for nominations is Wednesday, December 29, 2004.

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Mark Your Calendars

2005

WIAAP Board of Directors
Executive Committee Meetings:

Friday, January 21—10:00 AM
Saturday, January 22—AM
Wisconsin Medical Society
Madison

Friday, April 22—10:00 AM
Kalahari Resort
Wisconsin Dells

WAPF Foundation Meeting
Friday, January 21—8:30 AM
Wisconsin Medical Society
Madison

WIAAP Annual Meeting
Saturday, April 23, 2005
Kalahari Resort
Wisconsin Dells