



PULSE

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ACOP Board of Trustees Creates Student Research Fund

At its April 24, 2014 meeting in Kansas City, the ACOP Board of Trustees approved the formation of the Pediatric Research & Education for Students (PRES) Fund. The purpose of the fund is to provide a formal mechanism to support student research.

The ACOP has always been committed to its students and student clubs by keeping dues and registration fees at an absolute minimum. Once the corpus of the new fund reaches its target, the ACOP will institute an application and award system to fund students' research. All board members

have already contributed to the fund and it is hoped that there will be a very high participation rate from the members-at-large, no matter what the donation amount.

The American College of Osteopathic Pediatricians is a 501(c)6 organization. Donations to the PRES Fund may be tax deductible as allowed by law and will be acknowledged by the ACOP. Why wait?

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GRAPHIC DESIGN

Beverly V. Bernard

ASSOCIATION MANAGER

Kim Battle

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President's Message

Scott S. Cyrus, DO, FACOP
ACOP President

Unified Accreditation System

The Spring ACOP Conference held in Kansas City this past April was a great time and presented an excellent academic program. We shared some BBQ on the campus of KCUMB and were invited to a reception and tour of the state-of-the-art Children's Mercy Hospital. The attendance for this conference was nearly 200 physicians, residents and students. The ACOP CME committee continues its tradition of presenting a stimulating program for the membership. A "thank you" goes out to all the students and residents who contributed to the poster presentations and a personal congratulations to the Oklahoma State University College of Osteopathic Medicine Student Pediatric Club for winning "Student Club of the Year." The conference provided 20 category 1A CME credits for the membership. The Board of Trustees held its meeting and discussed a number of issues facing the ACOP...the greater of these is the merger of the AOA and ACGME Single GME Accreditation System.



Scott S. Cyrus, DO,
FACOP

As most of you know the AOA, AACOM and ACGME have signed a Memorandum of Understanding (MOU) that has generated a tremendous amount of questions for the entire profession. The AOA called a meeting on May 4 in Chicago and invited all specialty colleges, state associations, and others interested in reviewing the MOU, to listen to representatives from the AOA, AACOM and ACGME explain the details of the MOU. Stewart Hinckley, ACOP Executive Director, and I attended the meeting and had the opportunity to review the MOU. The AOA Board of Trustees' Student and Resident representatives voiced their opinion and are in favor of the single GME accreditation system, as are some of the specialty colleges, but the "devil is in the details." The ACOP Board of Trustees along with the Graduate Medical Education committee has been working diligently to communicate with the AOA our concerns over the MOU. Osteopathic pediatric graduate medical education residencies are unique because most of the programs are already dual-accredited programs. We want to protect this for our osteopathic students.

As it is written now in the MOU, pediatric residency program directors must be American Board of Medical Specialties (ABMS) certified. The osteopathic certified physicians currently serving as program directors should be allowed to continue their leadership of their programs. They have demonstrated their ability to produce excellently trained physicians and, if not, we should "police" our own programs and not allow an outside source to do it for us. The suggestion that our board certification is "less" is ridiculous and the ability for our graduates to provide quality compassionate care proves we are not less. We feel the ABMS and the AOBP should be equivalently recognized because of the quality of our graduating residents.

The AOA/ACGME final agreement must require that all Graduate Medical Education (GME) programs recognize the Comprehensive Osteopathic Medical Licensure Examination of the United States (COMLEX-USA) results as equivalent to meet examination criteria for admission into any single unified accredited residency program.

The osteopathic program directors in many of our dual-accredited programs provide their service "pro bono" by volunteering their time and services. They are invested in the education of the future osteopathic pediatrician. In the MOU, there will be a requirement for program directors to be financially compensated, which may indirectly push our positions to the allopathic ACGME side. With our directors typically volunteering their time and services to the programs, and now by placing an additional financial burden on the program, this could reduce the number of residency positions or close excellent programs, altogether hurting the students.

Continued on page 10



MELNICK at Large

Grandparents

By Arnold Melnick, DO, FACOP

Speaking of grandparents – which we weren’t – let me toss out a few observations.

In my practice years, whenever I encountered grandparents of my patients, I tried to convince them of the following axiom: Grandparents have just two roles to play or jobs to do -- one is to baby sit, and two is to spoil the grandchildren. There is fun and joy for the grandparents in both tasks and yet keeps them from interfering too much with the parents’ style of rearing their children.

Parents’ methods of bringing up their children may differ from the grandparents’ ideas or pediatric/psychological theories may have changed or the parents just don’t want to do it the old way. Implied in my aphorism is this: Don’t try to tell your kids how to raise their kids. That will only lead to terrible arguments or at least some tension between them -- and certainly it is not good for the children. They should not witness such disputes or be the object of a tug-of-war between the generations. Should a grandparent have a constructive suggestion to make, it should be done in a friendly way, as a helpful idea, without any blame or finger-pointing-- always polite and loving.

It also implies that the senior parents should not interfere with the junior parents’ discipline regimens. While we as pediatricians often foster certain recommendations, each generation seems to be moderately successful in their rearing of children. So, keep peace in the family, carry out your duties and enjoy your grandchildren to the limit.

Also, be careful not to countermand or ridicule any of the parents’ rules or discipline methods. Consistency is an important developmental tool for all children and none of us should confuse the children by our interference with what their parents have laid down. So, if the parent says, “No ice cream”, regardless of the grandparent’s own ideas, no excuse or rationalization should be used to modify or reverse this. Same with bedtimes, same with everything else.

So, if you follow this advice, you too will be able to say, as some wags have said, “If I had known that grandchildren would be such fun and such a joy, I would have had them first.”

Do you have some favorite anecdotes? Personal? Office? Are you willing to share them with me? I’d like to collect them and maybe share them with others. Please send them to melnick5050@comcast.net and be sure to include your name and address (street or e-mail). They will be appreciated.

NEW ACOP LEADERSHIP!

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JOURNAL REPRINT

Protecting Children From Child Sexual Abuse

By Martin Finkel, DO, FACOP

Editor's Note: Child sexual abuse affects one in four girls and one in seven boys. Martin Finkel, DO, FACOP offers smart, practical strategies for pediatricians to help protect their patients. This article originally appeared in Fall 2013 issue of New Jersey Pediatrics, the quarterly journal of New Jersey Chapter, American Academy of Pediatrics (NJAAP), as a collaborative effort between Dr. Martin Finkel, NJAAP and Prevent Child Abuse, New Jersey (PCANJ). It is being reprinted with the permission of New Jersey Chapter, American Academy of Pediatrics and Prevent Child Abuse New Jersey.

I write this for my pediatric colleagues.

We have seen the practice of pediatrics shift from a primary focus on the delivery of acute care to one which now focuses increasingly on the provision of anticipatory guidance and preventive care to assure optimal growth and development.

There is not one amongst us who doesn't routinely address the importance of back-to-sleep, seat belt safety, bicycle safety, water safety and environmental hazards, believing that the time taken to deliver each of these messages helps to reduce risk to children and has proven value. So I ask why it has been so challenging for us to incorporate in our prevention repertoire a message that addresses personal space and privacy, an issue that presents considerable risk to children and has the potential for serious long term physical and mental health consequences. Our failure to do so is not because we are unaware of the issue of child sexual abuse (CSA), but maybe because we find the topic unpalatable, don't have the language to address it, or are unsure of what would be effective.

We know that we can't just tell kids to wear their seat belts one time and expect that we have successfully addressed car safety.

Since CSA affects approximately one in four girls and one in seven boys, it is well overdue that we add this issue to our prevention repertoire. Even if we can't "immunize" every child against the possibility of CSA, we can likely help protect some from being abused.

Before we think about prevention, let's reflect on some basic facts; most children who experience CSA do so at the hands of someone they know and trust. That person is most likely to be a family member or someone who knows and has easy access to the child.

Although it is appropriate to talk about "stranger danger," the reality is that only a relatively few children are molested by strangers or registered sex offenders.

Most perpetrators do not intend to physically harm the child while engaging them in sexually inappropriate activities and thus few children ever present with physical examination findings that confirm sexual contact. Very few children actually experience sexual contact that involves the use of force and restraint that we call rape. About a third of perpetrators are juveniles and 40% of child victims are under six years old.

Few children ever present with physical examination findings that confirm sexual contact.

Most kids never disclose and those that do may not do so for some significant amount of time after the last sexual contact. There are many reasons for delayed or non disclosure which gen-

erally include fear of consequences, embarrassment, stigmatization, shame and thinking that they may not be believed. The primary impact of sexual victimization is not physical but psychological, with the potential for long term emotional and behavioral consequences. All children, regardless of their race, ethnicity, education or socioeconomic status, are at risk. No community or group is immune.

So you may be asking, if I were to deliver anticipatory guidance regarding personal space and privacy, when do I start? How often do I need to deliver the message? And how do I deliver the message? We know that we can't just tell kids to wear their seat belts one time and expect that we have successfully addressed car safety. We have to begin by delivering these messages early in childhood and continue to deliver these simple safety messages over and over again in a developmentally appropriate manner reinforcing the information. This same concept equally applies when delivering the message of personal space and privacy.

Let me suggest the following:

- Begin talking to parents about delivering information on personal space and privacy by three years of age.
- Tell parents that they should limit the individuals who provide genital, perianal and bathing care to those who they trust to reduce risk. Let them know that the more independence children have for their own genital/perianal care the better. Encourage parents to teach their children the appropriate names for their private parts so they have the language to communicate.
- A mom taught her five year old daughter that her private parts were called her "diamonds" and to tell if anyone touched her diamonds. She told her teacher that someone touched her "diamonds," but the teacher thought that was silly and didn't inquire further. As a result her disclosure and protection was further delayed. A three-year-old can say the word vagina or penis as easily as they can say "diamonds" or "ding-a-ling."
- Discourage co-bathing with siblings and adults.
- Introduce the concept of "OK and NOT OK" touching and the need to tell if anyone touches their "private" parts in a context other than providing care. A good time to have this discussion is right after completion of the non-genital components of the annual physical while the child is sitting in their underwear



Martin Finkel, DO,
FACOP

or a gown. Discussing OK and NOT OK touching provides an easy transition to the genital examination. In the context of the genital examination the child can learn the distinction between a doctor's examination and inappropriate touching.

- If you have heard about “good touch – bad touch” that is a phrase that was thought to be a way to communicate a prevention message. We have since learned that phrase is problematic because children do not anticipate being touched in a way that is “bad” by someone they know, love and trust. Touching in private parts can feel “good” and be confusing to children. If what the child experienced is perceived by them as being “bad” there is the possibility that they may think that they are “bad.” We do not want children to have to make a judgment on the quality of the touch thus the simplified message about what's “OK” and what's “NOT OK” now is a standard approach to introducing this concept.
- Parents should emphasize to their children that it is never OK to have a “secret” and if anyone tells them to keep a secret or they think they need to keep a secret, they need to tell two adults. Explain how “surprises” can be fine because we find out, but secrets are never okay. All of these messages should be delivered at every annual visit.



Parents should explain (to children) that if anyone ever touches them or makes them touch someone else's private parts they need to tell two adults right away.

If a child walks into a bedroom or bathroom and the parent needs privacy, they should tell the child they need privacy. Whenever the message of privacy can be reinforced it should. Children should be taught to respect siblings' need for privacy.

The pediatrician should deliver the above guidance annually at every health maintenance assessment and modify it based on developmental age.

If these messages are routinely delivered to young children as they grow older they will not only expect this discussion, but will accept it as well.

The parent has an ideal opportunity to reinforce the concept of a right to personal space and privacy starting with pre-schoolers when supervising their bathing. The parent explains that the parts of their body that are covered by a bathing suit or their underwear are called private parts and the reason they are called that is because they belong to them and they are the only one that can see them or touch them. Reinforce that the only people who are allowed to touch their private parts are:

- The child themselves when washing or wiping themselves;
- Parents or caregivers, if they need help with washing or having a wiping problem;
- Doctors checking to be sure their body is okay during a physical or when there is a problem with their private parts – with Mom/Dad in the room.

Parents should explain that if anyone ever touches them or makes them touch someone else's private parts, they should tell two adults right away. The reason for emphasizing two adults is that you want the child to tell someone who is a family member as well as someone who is not such as a teacher. When young children experience something inappropriate and then think about telling, they might be reluctant or afraid to tell a parent because they have processed the message from Mom/Dad as; Don't let anyone touch your private parts, I let someone touch my private parts, Mommy/Daddy is going to be mad at me. As a result, the child might turn to a teacher or another adult because they think they won't get into trouble. The important message is not who they tell but that they tell. Parents should emphasize to the child that they will not get into trouble or be punished for telling; in fact, they will be brave.

While supervising the bathing, the following questions or statements can be made to reinforce the concept. Periodically say: “Don't forget to wash your vagina/penis and butt and when you're done let me know and I will help you with your hair, or “Don't forget to wipe your private parts, Who is allowed to touch your private parts?” And “What do you do if someone touches your private parts?” Over time, when these simple messages/

questions are asked, the child will respond by saying, “Mommy/Daddy, I know that!”

Just because kids know what is OK and what is not doesn't mean they aren't vulnerable and they can stop someone from touching them inappropriately, but they may be more likely to recognize what they're experiencing is inappropriate and may disclose sooner rather than later.

Children armed with information about personal safety are six-seven times more likely to develop protective behaviors.

You might be asking, if I am going to add this message to the repertoire of anticipatory guidance, where is the science that it works. Unfortunately, the “science” of prevention is still evolving and there is no body of literature that purports a single message/approach that can be used to simply supply the magic bullet of prevention. We know that children armed with information about personal safety are six-seven times more likely to develop protective behaviors, enhance potential for disclosure and experience less self blame. As in the early development of every area of prevention, “common sense” was used to build a foundation that was then tested and led to the science. There isn't a parent who wouldn't want to protect his or her child against a sexually abusive experience. When we begin to give the parents the language to communicate these concepts, we educate children about this potential risk and empower them to help protect themselves.

It is the collective responsibility of parents, pediatricians and our institutions to deliver and reinforce children's right to personal space and privacy.

Now, it's time for pediatricians to integrate personal space/body safety into every annual health maintenance assessment.



Six Dangerous Words

By Robert Locke, DO, FACOP

In a recent commentary in *JAMA* (<http://jama.jamanetwork.com/data/Journals/JAMA/929397/jpo130038.pdf>), R. Scott Braithwaite, MD, writes about the dangers of the commonly used six-word phrase, “There is no evidence to suggest...” He argues that the phrase’s problem is “that it is ambiguous while seeming precise.” “There is no evidence to suggest” could mean: it’s never been studied; it’s been studied, but the evidence is inconclusive; or it’s been studied and there is excellent evidence that medicine “x” or procedure “y” is not beneficial. He goes on to point out that no studies have demonstrated the safety of looking both ways before crossing a street or the advantage of ambulances (as opposed to taxis) in transporting patients with acute GI hemorrhage. A few years back, Dr. G. Smith employed similar hyperbole when he discussed the rigors of evidence-based medicine. After all, there’s a lack of studies, especially randomized placebo-controlled trials, supporting the use of parachutes in reducing major trauma when stepping out of airplanes (<http://elucidation.free.fr/parachuteBMJ.pdf>).

I must admit, I am guilty of this. I often use the phrase with residents, nurses and parents, although there is better language available. Evidence-based medicine is extremely important, but it possesses frequently overlooked limitations. In pediatrics, we are often extrapolating results from children – sometimes even adults – with different conditions and confounders than the child we are treating.

Meta-analysis excludes all study formats except randomized controlled trials, ignoring the value of case-matched, cohort and observational studies that provide important insights into the real-life application of an intervention.

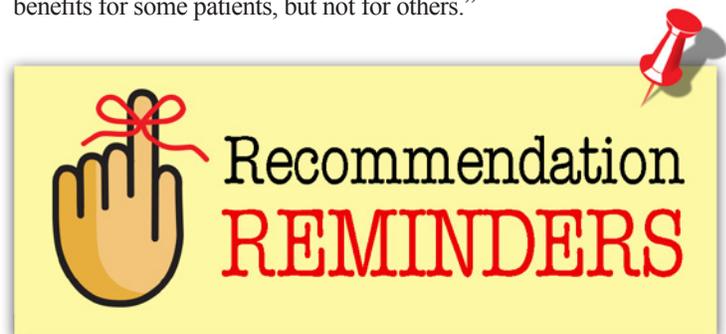
However, the phrase “In my opinion...” is also not without the great potential for harm. Ignoring high quality evidence in deference to anecdotal experience will not benefit patients. Whether in critical care medicine or an office-based medical home, meeting an individual patient’s or family’s needs requires both personalized and evidence-based medicine.

Communicating with precise language is a good start to a complex medical conversation. In his commentary, Dr. Braithwaite suggests alternative phrases to the ambiguous “There is no evidence to suggest,” including: “This is proven to have no benefit”; “Scientific evidence is inconclusive and we do not know what is best”; “Scientific evidence is inconclusive, but my reading of the literature and experience would suggest”; and “The evidence is indeterminate, with risks exceeding benefits for some patients, but not for others.”



Historical Highlights

The James M. Watson Memorial Lecture (at our annual meeting) was established in 1958 to honor our Founder. It was to be conferred on an outstanding member for distinguished service. The first honoree was Evangeline Percival, DO, member of the California group. Only twice have members been tapped to deliver the Watson Lecture more than once: Arnold Melnick, DO, (1962 and 1999) and Myron Magen, DO, (1970 and 1986).



Recommendation REMINDERS

A less-observed recommendation of the AAP is this one: “If a child comes under care for the first time at any point, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.” In the press of practice, and with all the necessary things to cover in a first visit, this may often be overlooked. Sometimes, if a child is first presented at an older age, it might be necessary to add an extra visit or two early to catch up.

It's polite to brag!

Osteopathic Student Pediatric Club and Residency Programs – Are you doing something exciting? Making a difference? Share your success with colleagues. Let us know what you are doing at your Student Pediatric Club. We'll highlight it the PULSE. It is polite to brag -- if you share it in the PULSE. Write to Kim@ACOPeds.org or ACOPublications@gmail.com with any questions or submissions.

TALES FROM ADOLESCENT MEDICINE



Dr. Castonguay is a physician at the Adolescent Health Center, Division on Adolescent Medicine, Department of Pediatrics, Akron Children's Hospital, Akron Ohio. She has completed a Fellowship in Adolescent Medicine and a Masters of Public Health at Nationwide Children's Hospital and Ohio State University School of Public Health. Questions or suggestions for future topics to be covered in this column? Write us at acopublications@gmail.com.

Polycystic Ovarian Syndrome

By Jessica S. Castonguay, DO, MPH

A 17-year-old female presents to your office with her mother for concerns of irregular menses. Menarche was at age 13 and initially cycles were regular. Over the last year, however, there has been an increasing amount of time between cycles. She also notes that her menstrual flow is getting heavier, requiring that she change her protection every three hours rather than every four to five hours. There is no associated cramping. Her main reason for coming in today is that she has not had a menstrual cycle for three months.

She denies any recent changes in weight, fever, increase in stress, or consistent physical activity. She follows with a dermatologist for acne, which is well controlled on oral antibiotics and topical tretinoin.

Further history obtained without mother present reveals coitarche (age of first intercourse) at age 15. Patient has had two male partners and reports no condom use with her current partner because he is "a really nice guy." She denies a history of STI, but has never been tested. She is not using any hormonal contraceptive.

BMI is at 90th percentile; other vital signs are within expected range. Her pertinent physical exam findings are below.

SKIN: scattered open and closed comedoes over nose and chin with minimal scarring to bilateral cheeks. Back with scattered papular acne, no cystic lesions. Few terminal hairs on upper chest, with shaved pubic hair between umbilicus and pubes.

EXTERNAL GU: shaved pubic hair, mucosa is pink and moist, no lesions noted. No clitoromegaly, no discharge noted at

the introitus.

I am concerned about three things with this young woman. First, she is sexually active and not using contraception. She needs a pregnancy test STAT! The most common reason for a young sexually active female to miss a period is pregnancy. Of course there are many other reasons, but this is one you would not want to miss. Delaying diagnosis of pregnancy decreases options available to the patient, and should she decide to continue the pregnancy, if pregnant, it would delay the onset of prenatal care.

Next, I am concerned that she is sexually active and not using condoms. I frequently have conversations that start off with, "Just because it looks clean..." Many patients have STIs and are asymptomatic! You can screen without a pelvic exam by obtaining a first-void urine (or dirty catch if you prefer) and sending it for nucleic acid amplification testing. The USPSTF recommends screening sexually active females under the age of 25 for chlamydia and gonorrhea annually and more often if they have multiple partners, new partners, or high-risk behaviors, such as condom non-use. Untreated infection could lead to pelvic inflammatory disease and resultant chronic pelvic pain or infertility.

Lastly, I am suspicious that this patient may have polycystic ovarian syndrome (PCOS). She is skipping cycles and has significant acne and hirsutism. If a patient has two of three Rotterdam Criteria, she can be diagnosed with PCOS. Criteria include oligomenorrhea or chronic anovulation, clinical or biochemical signs of hyperandrogenism, and polycystic

ovaries on pelvic ultrasound. Diagnosis does not necessarily require lab work or an ultrasound; however it can be helpful in ruling out other abnormalities. One might consider thyroid function tests, prolactin, DHEA-S, and free and total testosterone. FSH and LH would help rule out premature ovarian failure. 17-OHP could be obtained if there was clitoromegaly and concern for late onset CAH.

At a lecture on PCOS led by an OB/Gyn and an endocrinologist, the take home message was that it is ok to disagree on the best way to treat this constellation of symptoms. A foundation of treatment is supporting a healthy lifestyle including proper diet and exercise. This, of course, combats the insulin resistance that we know is part of PCOS. It can also help with weight loss in these often-overweight females. Some choose to include metformin. Combined oral contraceptives serve both to regulate menses, but also to increase sex hormone binding globulin, which in turn binds free testosterone. Other treatments are aimed at symptoms control such as acne medications and hair control measures. Follow up is dependent upon the provider and how involved they are with any prescribed lifestyle modifications.

A Few Take Away Points:

1. There is no one right way to treat PCOS.
2. Once "a teen" has joined the "sexually active club," she should be screened for gonorrhea and chlamydia at least once a year.
3. Always think pregnancy when a sexually active female (or a squirrely one) presents with a late or missed menses.

**Update on AOA,
AACOM and
ACGME Proposed
Single GME
Accreditation
System**

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Section of the ACOP website
acoped.org**

2014 ACOP Spring Conference Award Winners

RESEARCH POSTER WINNER



Poster #18: The Efficacy and Comparison of Non-Invasive Mechanical Ventilation (NIV) with High Flow Nasal Cannula (HFNC) Therapy in Management of Severe Respiratory Distress in Infants

¹Alexandra Bowling, OMS III; ¹Siobhan Drumm, OMS III; ¹Jamie Fultz, OMS III; ¹Anita Iari, OMS III; ¹Brena Haughey, OMS II; ¹Marcia Reeves, OMS II; ¹Hina Siddiqui, OMS II; ¹Maria Snapp, OMS II; ²Nicola Sahar, BHSc; ³Kim Cantrell, RTT-NPS; ¹Dalia E. Meisha, DDS, MPH, DScD; ^{1,3}Hanna S. Sahhar, MD

¹Edward via College of Osteopathic Medicine; ²McMaster University; ³Spartanburg Regional Healthcare System

Pictured above: Dr. Abe Bressler, ACOP Research Committee Chair, presents the Best Research Poster Award to Alexandra Bowling (left) and Siobhan Drumm (right).

CASE STUDY POSTER WINNER

Poster # 6: Drowning and Therapeutic Hypothermia: Dead Man Walking

Angela Kavanaugh, DO, Jamie Cohen, DO, Jennifer Davis MD FAAP,
Department of PICU

Chris Evert Children's Hospital, Broward Health Medical Center

Pictured to the right: Dr. Abe Bressler, ACOP Research Committee Chair, presents the Best Case Study Poster Award to Drs. Jamie Cohen and Angela Kavanaugh.



STUDENT CLUB POSTER WINNER

Poster #22: VCOM Carolinas Campus ACOP Student Chapter

Elizabeth Williams OMSIII; Marcia Reeves OMSII;
Jessica Gancar, OMS II; Elizabeth Gatan, OMSII;
Mia Snapp, OMS; Hanna Sahhar, MD, FAAP

Virginia College of Medicine-Carolinas Campus

Picture to the left: Dr. Abe Bressler, ACOP Research Committee Chair, presents the Best Student Club Poster Award to representatives from VCOM Carolinas Campus.

HAROLD H. FINKEL, DO AND ARNOLD MELNICK, DO COMMUNITY PEDIATRICIAN OF THE YEAR Louis J. Schaner, DO, FACOP



Left photo: Dr. Louis Schaner (left) is presented with the Harold F. Finkel, DO, and Arnold Melnick, DO, Community Pediatrician of the Year Award by Dr. Carl Backes.

Right photo: Dr. Martin Finkel (left) sits with Dr. Schaner as he is congratulated by telephone by Dr. Arnold Melnick.

STUDENT CLUB OF THE YEAR Oklahoma State University College of Osteopathic Medicine



Scott Stroshine, (left) President of OSU-COM Student Club, accepts the ACOP Pediatric Student Club of the Year Award from ACOP Student Trustee Jason Jackson.



Innovation is Not Always a Good Thing: A Case for e-Cigarettes

Editor's Note: There is a general misperception that e-cigarettes are "safe". As Dr. Hendriksz describes, that is not the truth. To appreciate the depth of the scientific evidence, the PULSE is including some of the references Dr. Hendriksz utilized.

By Tami Hendriksz, DO, FACOP

Some innovations improve the quality of life to such an extent that it is difficult to remember what it was like to possibly live without the invention. Other creations may seem initially to bring forth positive change, but over time their negative impact far outweighs the novelty of modernization. Such is the case with electronic cigarettes.¹ These devices deliver a heated aerosol of nicotine in a way that simulates traditional cigarettes while delivering lower levels of toxins than a conventional cigarette. They offer a new gateway for nicotine inhalation and have shown to be very tempting to children and adolescents. When electronic cigarettes first came on the market in the United States in 2007² they were touted as cool, safe and fun. They even had a hip nickname, e-cigarettes (or e-cigs, for short), that all too closely resembled the names of popular electronic devices like iPads and iPhones.

E-cigarettes have enjoyed a marketplace that is relatively free of regulation. They have been aggressively marketed using the same media channels and messages that conventional cigarette companies used in the 1950s and 1960s.³ Furthermore, they enjoy the addition of a strong advertising presence on the Internet. Data from years of research has shown that youth smoking is greatly influenced by youth exposure to cigarette advertisements.⁴ Combine that with the fact that e-cigs are available in flavors like chocolate or strawberry (the same flavors that have been banned in the conventional cigarettes in the U.S. because of the increased appeal to youth) and it is not surprising that the use of e-cigarettes among adolescents continues to increase at a rapid rate. The National Youth Tobacco Survey (NYTS) from 2011 and 2012 revealed that e-cigarette use doubled

between those years among youths in grades six through 12, from 3.3% to 6.8%.⁵ There is also a high incidence of concurrent traditional cigarette use with e-cigarettes among adults and adolescents.

E-cigarettes were initially marketed as smoking cessation aids and as a healthier replacement to conventional cigarette smoking. The longer e-cigs are on the market, the more data is collected and reported that shows that e-cigarettes are very rarely a successful pathway to quitting smoking.⁶ New studies have also demonstrated that there are still harmful, detectable levels of nicotine and other substances in the vapor let off by an e-cigarette, thus dispelling the claim that they can be smoked indoors and around children without the risks associated with secondhand smoking.⁷ Studies have demonstrated that children of smokers are more likely to pick up the habit than children who grow up in non-smoking households.⁸ As more parents feel that e-cigarettes are a safe alternative, there is an increase in pediatric exposure to e-cigarettes. Parents may initially switch to e-cigarettes with the intent of quitting smoking altogether. Unfortunately, they may believe that their children are safer around the e-cigarette vapors, so once they begin using e-cigarettes there may be less motivation to quit smoking.

Children and adolescents have a number of reasons to feel tempted to try e-cigarettes: the direct and aggressive marketing campaigns, the exciting flavors, the novelty of a new electronic device, and increased exposure of witnessing their parents and other adults use. It is important that healthcare professionals remain up-to-date on the latest trends and scientific research so that they can best counsel their

patients on risks to avoid. Not all that glitters is gold – it is important to remain aware, promote educated consumerism and not allow ourselves to get caught up in the excitement of the novelty of innovation.

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**Reflections by Past Presidents
of the ACOP**

Edited by Steven Snyder, DO, MS, FACOP

Michael Musci, DO, MBA, FACOP (ACOP President: 2002-2004)

I am writing this as I fly back from the ACOP Spring Conference in Kansas City. I've been putting off sitting down and placing thoughts on paper (just ask Steven Snyder). Anyway, I realized there was no better time to sum up my perspectives about the ACOP than now; fresh from a meeting that was filled with education, excitement, eating, and enthusiasm for the future. Simply put, the ACOP has never been stronger and I believe it is well positioned to embrace the new healthcare world we are entering.

I was the first President of the ACOP to serve a two-year term. We adopted that after toying with it for a few years. We studied it, debated it, worried about it, and finally did it with more than a little blind faith. The driving force behind the change was we felt one year wasn't enough time for a President to really get things started. Our college was much smaller then. We were more than a little concerned about our future. Would we remain a viable professional organization? How could we attract osteopathic pediatricians trained in allopathic programs, certified by the ABP and members of the AAP? Would our fledgling efforts to attract students interested in pediatrics pay off? Those were the questions of the day.

Some may ask why the concerns we had were so seemingly fatalistic. I think we saw such challenges and didn't think we had enough time and resources to get the job done. Frankly, by extending the Presidency by a year, we had people on the Executive Committee for longer. You're committed for six years and we didn't exactly have an abundance of people stepping up to serve. Things have certainly changed for the better. Today, I'm struck by the balance of folks who have been around for a while and new people as well. We get the benefit of both "institutional knowledge" and fresh thinking and energy. Bob Hostoffer, DO, reminded me this weekend of the first "poster session" when he brought his posters rolled up to a small mid-year meeting outside Washington, DC. This year's meeting in KC had 21 posters and a challenge to double the number at next year's 75th celebration meeting in Ft. Lauderdale. That's real progress!! The posters were far ranging, relevant and professional.

I'm not one to engage in a lot of reminiscing. This weekend, I allowed myself to do a little more of it than usual. It was the "muse" I needed to get this column started. I found myself looking around the meeting room with amazement more than once at all the young people. Becoming a Pediatrician is a calling for most who become one. After meeting some of the students and residents, I believe our nation's children are going to be well cared for in the future. They're smart, personable, curious and committed. It gives me great joy and hope to know that—to know that the legacy of osteopathic pediatricians caring for America's children and the legacy of the ACOP serving those who heed the calling will be in such capable hands.

In the JOURNALS



ACOP Members in Print

Complementary and Alternative Medicine Use in Women During Pregnancy: Do Their Healthcare Providers Know?

BMC Complementary and Alternative Medicine 2014,
14:85 doi:10.1186/1472-6882-14-85

Robert Locke, DO, MPH, FACOP and colleagues.

A free electronic version of this article is the complete
one and can be found online at:

<http://www.biomedcentral.com/1472-6882/14/85>

*If you or someone you know has an article
in print, share the good news and let us
know at ACOPublications@gmail.com.*

President's Message

Continued from page 2

A smaller portion of our residency programs is solely AOA accredited. The ACOP is moving forward to assist in the creation of additional rural, community and hospitalist-based residency programs. These residency programs have shown that they fit the needs of our students and train our residents in a concentrated way to serve their patients. These programs may have difficulty with the ACGME accreditation process, which effectively would close current GME opportunities for our students. This will essentially make it more difficult for osteopathic students to compete for GME.

I realize that the move to a single accreditation system will allow residents to compete for allopathic fellowships in the future and I don't want to deny any of our DOs an opportunity to further their education. The concern we have is as we move down this road, is that the pediatric osteopathic residency position will be blended together and our students will be left without a graduate medical education position. We have joined with the ACOFP to support their resolution and have submitted our own resolution to the AOA House of Delegates (HOD) for the July 2014 meeting in Chicago. The ACOP wants to work toward protecting our students so they have graduate medical education positions and are not left out in the cold.

Remember, our next ACOP meeting will be in Seattle, WA, with the AOA in the fall. Next year the ACOP will celebrate our 75th Anniversary, April 30-May 3, 2015 in Fort Lauderdale, Florida. We are planning some exiting events and looking forward to wonderful fellowship. We also will be joined by the AAP Section on Osteopathic Pediatricians and will be providing another outstanding didactic program. See you in Seattle!

Visit www.acoped.org for membership information

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 Suhail M. Salim, DO..... New Hyde Park, NY

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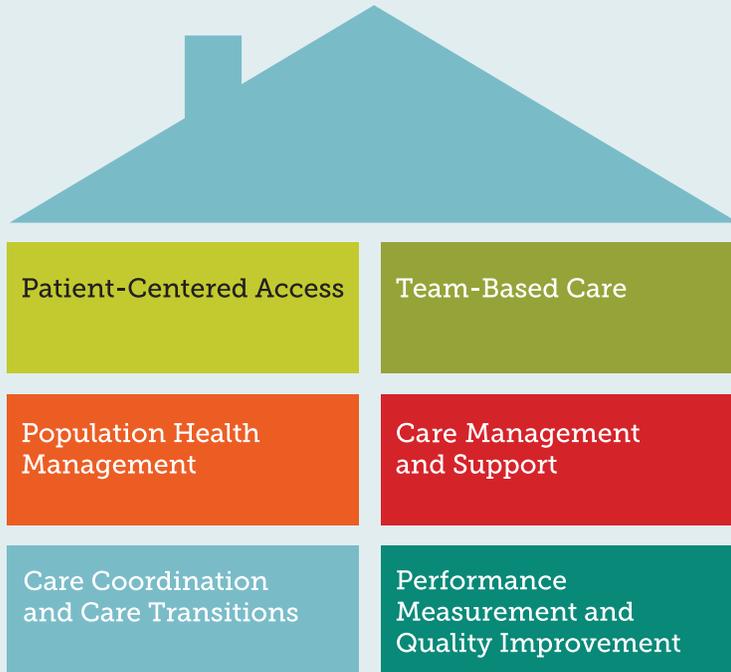
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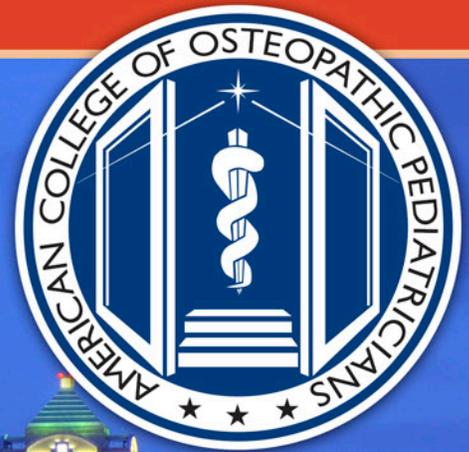
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