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THE QUARTERLY PUBLICATION OF THE AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS



2006 Spring Meeting Review

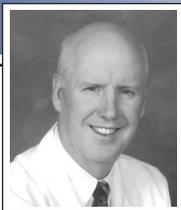
The ACOP 2006 Spring CME Conference at the Pointe Hilton Squaw Peak Resort, April 21-23 was a record-breaking success! The theme of the meeting, “Conduit for Success: Linking Osteopathic Educational Institutions with our Professional Society” attracted 177 scientific registrants from 28 states, including 64 medical students and 8 residents. Registration was 136 at the 2005 Spring Conference in Chicago.

Besides the balmy weather in Phoenix, participants enjoyed educational lectures on practical topics beginning on Friday with back-to-back lectures from Dr. Gary Silber on IBS vs. Chronic Abdominal Pain and GI Update: Constipation and Reflux. Adolescent Eating Disorders by Dr. Eric Hegybeli, Pediatric Surgical Emergencies by Dr. Stuart R. Lacey and Poison Control by Dr. Karen Scharlatt were also topics participants met with extremely favorable review. At the end of the day, the President’s Reception allowed participants

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CATCHING UP WITH...

...Michael E. Ryan, DO, FACOP



Recently, *PULSE* caught up with Past President Michael E. Ryan, DO, FACOP, knowing that he is an icon of Graduate Medical Education in the ACOP. Talking with him confirmed that, but also brought out that there is a much broader aspect to this fine pediatrician.

Like so many of us, he always wanted to be a pediatrician — because physician and pediatrician were synonymous for him. Growing up in the Poconos, he was inspired to become a DO by several fine osteopathic physicians who were his doctors.

Mike Ryan earned his DO degree at the then Kansas City College of Osteopathic Medicine, where he was motivated by great teachers and pediatricians, Pat McCaffery and Phil Jones. He then interned at Tri-County Hospital in Springfield, PA. Even though interest in other fields on rotations distracted him briefly, he always came back to Peds. He took his first year of residency there with two of his greatest idols, the Santuccis: Tom, Sr. and Tom, Jr. When they both retired, he finished his residency with two years at Geisinger Medical Center, Danville, PA. And he’s been there ever since, except for a hiatus for an Infectious Disease Residency at St. Jude’s Hospital. Presently, he is Chairman of the Department of Pediatrics at Geisinger.

Looking back, he recalled, with pride in his voice, putting together the educational program for the College’s 50th

Anniversary Celebration in St. Thomas and the published book it produced — *The Golden Anniversary of the American College of Osteopathic Pediatricians*. That was during his presidency. He is equally proud of his considerable role in training residents at Geisinger over the years — some 200 of them.

So what did he think was the highlight of his presidential term in 1989-90? “Our significant achievement was leading ACOP to be the first College to accept AMA specialty training, and the first to have joint accreditation of AAP and ACOP – with the initial one at Geisinger.”

And what impresses him about ACOP meetings? Like so many members, it is the family atmosphere. “I always looked up to the seniors present, and now that I see younger members there, I hope they continue to perpetuate the family atmosphere.”

Mike says the quality of programs at our meetings is outstanding — splendid speakers on interesting topics. He feels that with our smaller audiences, there is more interaction, making the meetings most valuable to everyone.

His long-standing contribution to ACOP is his service on the Committee on Graduate Medical Education — ten years as a member, then ten years as Chairman. His experience and love for ACOP show through totally in this activity. He still has

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SITES FOR SORE EYES

Help for Childhood Obesity?

By Gregory Garvin, DO, FACOP

I recently gave a lecture on the SIDS guidelines that were published in the policy statement by the American Academy of Pediatrics in the November, 2005 issue of *Pediatrics* at the Iowa Osteopathic Medical Association Annual Spring Meeting. The speaker that preceded me was Heidi Oberrieder, a registered dietician. She gave a wonderful talk about pediatric obesity and provided a page of “Healthy Resources” (websites). I’m going to mention a few for everyone’s “favorites” as this is a growing problem we all need to be on the cutting edge.

www.kidsnutrition.org: Sponsored by the USDA Center for Nutrition Research and Baylor College of Medicine. Calculate a child’s BMI (weight category) and calorie needs. Includes facts, interactive items, a free newsletter and great links to other sites.

www.americaonthemove.org: A partnership to promote healthy eating and

active living. Sign in to get daily tips, track your progress and access great links to websites.

www.smallstep.gov: A White House program for making small realistic dietetic and lifestyle changes. It has a new downloadable resource entitled, *A Parent’s Guide to healthy eating and physical activity*. (102 pages).

www.quakeroatmeal.com: Developed by the American Dietetic Association. Click on the “Strive for Five” on the left side of the home page for a month’s worth of ideas for making healthy changes. Various interactive tools include a Hunger Scale and Portion Distortion.

Well, I’ll include some more sites in the next issue... If anyone out there has a site to pass on to the ACOP membership, please email me at: garvin@genesishealth.com.

Happy Surfing!

Catching Up With....

Continued from page 1

a strong interest in this area because he considers it very important to the College — as well as to our residents.

On the personal side, Mike and his wife Kieran are parents of four children, ages 24 to 35, none of whom are in the medical field. They are also blessed with four grandchildren.

Hearing a flattering statement about his accomplishments, Mike replied, “I have received much more than I have put into ACOP and this profession — much more than I deserve. I still wonder why I get paid for doing the things I love so much.”

You can tell that Mike is driven to quality in everything he does. No wonder he is such a quality pediatrician — and such a long-standing, valuable member of ACOP.



Welcome New Members

Physician Members

Thomas Paul Francis, DO.... *Maplewood, NJ*

Sabah Kalyoussef, DO.. *North Brunswick, NJ*

Rumi Lakha, DO..... *Gardena, CA*

Kathleen Ann Weber, DO..... *Phoenix, AZ*

Student Members

Maria G. Dunn *Blacksburg, VA*

Richard Kampanatkosol..... *Glendale, AZ*

Michael Luceri..... *Voorhees, NJ*

Susan Marchiano..... *Voorhees, NJ*

Ashesh B. Parikh..... *Blacksburg, VA*

Heather Tyrell..... *Blacksburg, VA*



MELNICK at large

By Arnold Melnick, DO, FACOP

Just What is “The Pediatric Age”?

Ask a number of pediatricians what the pediatric age group is and you’ll probably get a number of different answers. And, you know, they may all be right.

I like to look back over the years at that question and see the many changes that have occurred.

A few years before I graduated medical school (1945), many obstetricians took care of their own newborns — and some even cared for prematures. The pediatrician was called when there was difficulty or trouble. Now, almost all newborns are under the care of pediatricians.

Around the same time, many pediatricians limited their practices (or were limited) to the very early years of life — except mainly sub-specialists practicing in children’s hospitals. You must remember that in the forties and before, infections made up a major portion of young child illnesses — whooping cough, measles, scarlet fever, pneumonia and many others. There were no definitive therapies for them. I saw all of them. You see practically none today. When I graduated, sulfonamides had just come out and penicillin was in its infancy. Initially, only aqueous penicillin (injected every three or four hours) was available. The first long-acting penicillin started to appear shortly after I opened my office. So there were plenty of infections to keep pediatricians busy handling just the tiny tots, with none of today’s “miracle” drugs to cure them.

Treating a pneumonia case or a child with whooping cough, for example, meant daily (at least) visits to the home (we made a lot of house calls). DOs in particular did this, because they had a treatment not otherwise available — especially in those two diseases: lymphatic pump. And it had to be applied frequently. Many of us taught the mothers to administer a lay form of it to supplement the child’s care between our visits.

Once specific therapy shortened treatment times, the pediatricians began seeing older children, or rather, they kept seeing children beyond their previous age limits. Then the level became 5 or 6 years of age.

Ultimately, the age limit went up (to provide enough patient flow?). When I went into practice, we generally had a top age of about 11 or 12 years—and that’s what most of the pediatricians did.

With their increasing concentration on the growing child and their better understanding of these patients, the pediatricians became more adept and skilled (and they became recognized for it) — so they continued to raise the top age.

For a rather long time, most pediatricians set their limits at about the start of adolescence. Once again, as the pediatrician’s skills increased, there was an understandable take over of the young teenagers, and ultimately the older adolescent.

All these considerations contributed to the development of sub-specialists; that’s why we now have neonatologists, infectious

disease specialists and adolescent medicine specialists.

I, among others, developed a special interest in adolescents late in my practice days. In my private practice, I had several college students who preferred to stay with me as patients because I knew them so well, although I must admit most of them left me once they started college. One I remember in particular, was a young lady in whom I made a diagnosis of diabetes when she was 10 years old. She chose to remain my patient, and whenever I diagnosed a new diabetic, she would make a special trip home from college to counsel that child. That’s one of the rewards of practice that no one talks about.

So what is correct? The last I looked, the AAP considered the pediatric age to go up to 21 years, and the federal government used 20 years. What I think is important is what the individual pediatrician wants to do. I always told interns that when they went into practice, they should only keep those patients with whom they were comfortable.

If asked to give advice, I would follow that philosophy to determine my pediatric age group. Handle the ages with whom you feel a kinship. Keep those patients with whom you can develop a symbiotic relationship. Build your practice around patients with whom you share empathy. You will be happier and your practice will flourish!

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Medicine has been “Corporized”!

By Gregory L. Garvin, DO, FACOP, FAAP
Associate Editor, *Pulse*

Once in a while I feel like getting on a “soapbox” and I like the fact that the *Pulse* has a way to do that! So here goes...

Everyone says “medicine” was going to be “Socialized”, but in my mind, it’s been “Corporized” with many of the same endpoints. The same thing happened long ago to the business world. This was done in our profession in an attempt to affect the bottom line which drives most of the changes we see in everything in our hectic lives.

To be successful in the future, we will all need to be part of a “Health System.” This, I’m told, is to get one-payor contracting. It’s all about getting patients. Physicians not part of a Health System will be able to see patients who are “private pay,” but that market, I imagine, will be pretty small.

This entire introduction leads me to my point as an Osteopathic Physician in a corporate-controlled industry. As part of a Health Care System, I belong to a large primary care group and sign a service agreement. I was instrumental in helping set up this group here in my own community. I’m proud of that, but there are changes that have occurred that I would like to let the “Buyer beware.”

The point I’m trying to get across is that it goes without saying that if Corporate Medicine is to be successful, it has to make a positive impact on the bottom line. I claim that my generation of physicians is the last of the “fat cats”, as we formed a large primary care group and sold off the stock or “ownership” of our practices for a price much more than we could have done individually. Once a critical mass of employed physicians exists (and it is nearly there, especially in larger markets), the Health Care System can get the rest of the physicians they need without having to “buy” them.

Because of these developments, the Service Agreement tries to spell out what will be expected of the Health Care System and what will be expected of the physician. An area I tried to address at the formation of this primary care group, but was not heard, was the area of compensation for continu-

ing education and dues and licensing. What appears to be a generous budget, soon appears to be inadequate, especially for the Osteopathic Physician. Many of us are in the same boat. We want to stay involved in our own profession and remain members of our respective Osteopathic Societies, but at the same time, because of our professional relationships with many of our partners, we also want to belong to the local medical society and even the American Academy of Pediatrics. Because of this we need to pay double dues for various memberships, which cuts into our CME budget.

Since the American Osteopathic Board of Pediatrics certifies many of us, we MUST be members of the American Osteopathic Association to maintain our certification. This, in my mind, is just another hidden tax, since after the CME budget is used up, any fees for dues or licenses must be paid with after tax dollars. Most of us who have been in practice for several years, feel this should be a business

expense, but the IRS rulings on this do not allow for this. So, you are now paying this hidden tax to operate. I write this to the younger membership, who will need to be knowledgeable, as well as to some of us old guard, who are becoming part of the corporate world of medicine.

Members are encouraged to submit articles of interest in Pulse. If you would like to express your opinion or offer suggestions, send your comments to Pulse Editor, amelnick@nova.edu.

Editor’s Note

This chart on the facing page was deemed by the *Pulse* editors to be worthy of duplication for *Pulse* readers, and is printed here after consultation with several pediatricians. It appeared in *Quest*, official publication of the Muscular Dystrophy Association, Volume 13, Number 2, March-April, 2006, and is being reprinted with the permission of their editors.

PEDIATRICS... and then some!

Some pediatricians have moved their attention to areas tangential to or complementing the practice of Pediatrics. This is one of a series.

Dwain L. Harper, DO, FACOP

Several years of pediatric practice following graduation from CCOM in 1963 and a residency at Doctors Hospital in Columbus, led Dwain gradually into several administrative and executive fields. He has done a great job.

Presently, he is an associate of Allied Health Services (AHS) and Consultant to the AOA for the Clinical Assessment Program (a pioneering program) and for area-wide hospital quality initiatives.

In 2002, one of AHS’s initiatives received the JCAHO National Codman Award for Community Health Care Quality in Dayton.

From 1989 to 1999, he was President and Executive Director of the Cleveland

Health Quality Choice Program, where he pioneered the first voluntary public report card for hospitals, receiving world-wide recognition.

Prior to that, he was Executive Vice President and Chief Medical Officer of the Sisters of Charity Health System in Richfield, OH, and Vice President for Professional Affairs for the UMDNJ-Kennedy Memorial University Hospitals.

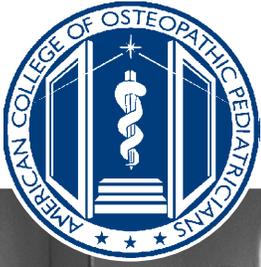
Dwain has handled these groups just like he handled babies — with close attention, careful study, much forethought and great tenderness.

Cardiac Effects of Muscular Dystrophies

Disorder	Cardiac Effects	Disorder	Cardiac Effects
Duchenne and Becker MD (dystrophin mutation)	dilated cardiomyopathy very common; severity varies	Fukuyama congenital MD (fukutin mutation)	dilated cardiomyopathy can occur and can be severe
Female carriers of Duchenne and Becker MD (dystrophin mutation)	at risk for cardiomyopathy	Congenital MD 1C (fukutin-related protein mutation)	dilated cardiomyopathy common
Limb-girdle MD 1A (myotilin mutation)	not reported in LGMD, but some myotilin defects associated with cardiomyopathy	X-linked Emery-Dreifuss MD (emerin mutation)	arrhythmias and conduction defects common; cardiomyopathy may occur
Limb-girdle MD 1C (caveolin mutation)	unknown	Female carriers of X-Linked Emery-Dreifuss MD (emerin mutation)	10 percent to 20 percent have arrhythmias and conduction defects
Limb-girdle MD 2A (calpain 3 mutation)	unknown	Chromosome 1 Emery-Dreifuss MD (lamin A/C mutation)	arrhythmias and conduction defects common; cardiomyopathy more common than in X-linked EDMD
Limb-girdle MD 2B (dysferlin mutation)	not seen so far	Myotonic dystrophy type 1 (chromosome 19 mutation)	arrhythmias and conduction defects common; cardiomyopathy can occur
Limb-girdle MD 2C, 2D, 2E, 2F (gamma, alpha, beta or delta sarcoglycan mutation)	dilated cardiomyopathy common in LGMD 2C, 2E and 2F; may be less severe in LGMD 2D (alpha-sarcoglycan mutation)	Myotonic dystrophy type 2 (chromosome 3 mutation)	arrhythmias in 20 percent; conduction defects can occur
Limb-girdle MD 2G (telethonin mutation)	unknown	Facioscapulohumeral MD (chromosome 4 mutation)	may have slightly increased risk of arrhythmias or blocked conduction
Limb-girdle MD 2I (fukutin-related protein mutation)	dilated cardiomyopathy common	Dysferlin-related distal MD	not seen so far
Limb-girdle MD 2J (titin mutation)	not reported in LGMD, but some titin defects associated with cardiomyopathy	Titin-related distal MD (titin mutation)	cardiomyopathy can occur
Congenital MD 1A (laminin alpha 2 mutation)	dilated cardiomyopathy uncommon; mild if occurs	ZASP-related distal MD (ZASP mutation)	cardiomyopathy occasionally occurs
Ullrich congenital MD (collagen 6 mutation)	unknown		

Chart courtesy of the Muscular Dystrophy Association

Adapted from "Cardiac Involvement in Muscular Dystrophies: Molecular Mechanisms," by Fiona Goodwin and Francesco Muntoni, *Muscle & Nerve*, November 2005; Washington University St. Louis Neuromuscular Home Page, www.neuro.wustl.edu/neuromuscular



AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS 2006 Spring Conference Highlights



Spring Meeting Review

Continued from page 1

to meet the ACOP Board of Directors and network with peers.

There were a total of 19 posters presented during the Friday afternoon viewing session and refreshment breaks. Monetary rewards and plaques were presented during lunch to the three Poster Award winners: Maureen G. Leffler, DO, MPH, First Place; Anna Ryabets-Lienhard, BS, Second Place and Sowdhamini Wallace, DO, Third Place.

Dr. Scott Ostdiek started Saturday morning with an informative lecture titled TB to Be, or Not TB. Other topics of interest were International Adoption Issues by Dr. Stanley E. Grogg, Pediatrics and the Law by Patricia A. McCoy, Esq., School Safety Issue by Dr. Frenche Colbert, Pediatric Neurosurgical Issues by Dr. Francesco T. Mangano and Interesting Cases by Dr. Chandra Delorenzo.

Parallel sessions were offered on Saturday in which Pediatric Residency Program Directors were given an opportunity to present their programs to student participants while Pediatric Department Chairs met separately and covered a number of topics including: core curriculum, learning objectives, pediatric OSCE examinations, council on medical student education in pediatrics, preceptor development and post-rotational question bank. These sessions were met with great enthusiasm so expect to see this repeated at future meetings!

Oral poster presentations were offered on Saturday afternoon. Participants commented these were excellent and asked that they also be repeated at future meetings.

The conference ended on Sunday with lectures on ADHD and Co-morbidities by Dr. Joseph L. Lillo, Pediatric Behavior and Development by Dr. James E. Campbell, Diagnosing Autism by Dr. Randall K. Riccardi and Depression and the Black Box Warning by Dr. Robin Krause Blitz.

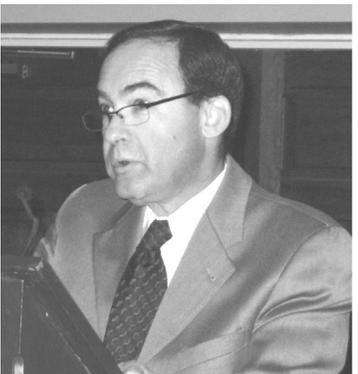
Plans are well under way for next year's Spring Meeting, which will be a joint meeting with the AAP in Orlando, June 28 – July 1, 2007.

SAVE THE DATE

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BOOK REVIEW

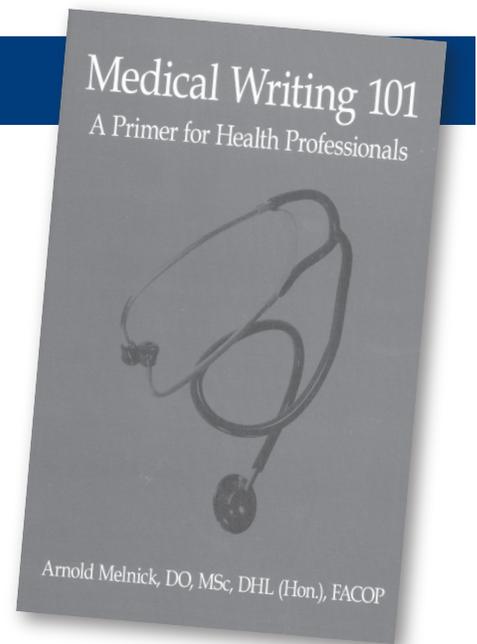
by Stan Grogg, DO

Medical Writing 101 by Arnold Melnick, DO

For those entering the practice of medicine, *Medical Writing 101* is a *MUST*. Dr. Melnick's topics include subject topics, formats required, where to publish, available resources and pitfalls. Examples of each of the topics are covered.

Whether one is writing a consultation to a patient or to another health care provider, chart notes, an article to be published or a letter to an insurance company, communicating appropriately is important. All medical personnel need to obtain a copy of this book for review and to use as a reference for writing. This manuscript is well written and to the point. Recently, this publication became required reading for all of the Oklahoma State University-College of Osteopathic Medicine pediatric residents.

Medical Writing 101: A Primer for Health Professionals, published by AuthorHouse, Bloomington, IN, 91 pages, soft cover, list price \$10.90, is available directly from the publisher for \$7.81 plus postage: 888-280-7715 (toll-free) or BKorders@authorhouse.com or any on-line bookstore.



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or by email at joye@ACOPeds.org