PULSE

THE QUARTERLY PUBLICATION OF THE AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS

WINTER • 2014

PLAN NOW TO ATTEND!

ACOP 2014 Spring Conference

Please join us for the 2014 Spring Conference at the Sheraton Kansas City Hotel at Crown Center in Kansas City, MO on April 25-27, 2014.

The Conference Offers Lots of Activites for Attendees:

OMM Workshop

Optional workshop (additional registration fee) to be held at the Kansas City University of Medicine and Biosciences the evening of Thursday, April 24, 2014.

Pediatric Critical Care & Emergency Medicine Sessions

- Surviving Sepsis
- Pediatric Drowning
- Pediatric Airways/Foreign Bodies
- Evalutaion of Stridor in the Pediatric Patient
- Lacerations, Bites and Abcesses: What's New in Wound Care?
- Interesting Cases from the Pediatric Emergency Department

Allergy Workshop

Endocrine Sessions

- Type 2 Diabetes/Pre-Diabetes
- Common Pediatric Dermatology/ Rashes
- Thyroid Disease

Pharmacology Sessions

- Clinical Applications of Pharmacogenomic-Based Medicine in Pediatric Practice
- SSRIs and Serotonin Syndrome – Etiology, Rocognition and Management

OCC Mini Board Review

2014 James M. Watson Memorial Lecture

Hematology and Oncology for the Practicing Pediatrician Sessions

- Kids with Brain Tumors
- Sickle Cell Anemia
- Coagulation Disorders
- Leukemia, Neutropenia, Thrombocytopenia

Technology: Reverse Mentoring

Student representatives from the new ACOP Social Media Taskforce will be available to mentor attendees on using mobile devices and web-based applications in clinical settings.

Members Lunch & Business Meeting

Posters

Submit your research, case studies and student club activities.

Awards Reception

Pediatrician of the Year, Best Posters and *Student Club of the Year* awards will be presented.

Wellness Activities

Participate in the morning activities to start your day right!

Watch for a full conference brochure to be available soon.

what's inside . . .

Click on the article title below to view your selection!

PULSE is published four times a year in conjunction with the American College of Osteopathic Pediatricians, 2209 Dickens Road, Richmond, VA 23230-2005; (804) 565-6333 or fax (804) 282-0090.

MELNICK at large

Think Pediatrics...and Laugh

By Arnold Melnick, DO, FACOP

Among the many groups of people that are the subject of jokes, children and their parents are frequently found. Many times, humor is found in the actual words of children, their clever replies, their cute answers and their lovable comments. As an interlude for this column, I present to you several humorous comments about children. And I think that we, as pediatricians, can probably appreciate them more than most other groups of people.

Try to see if you can keep from smiling at these comedic lines, or can avoid tying them into some of your own experiences:

Training babies is mostly a matter of pot luck.

Kids are a comfort in your old age – and they help you reach it faster as well.

It seems a shame that most parents weren't given their neighbors' children, because those are the only ones they know how to raise.

Children never put off until tomorrow what will keep them from going to bed tonight.

Children should make great waiters when they grow up. They never come when you call them.

If you really want your kids to do what you say...say nothing.

- Courtesy of Bob Monkhouse: Just Say a Few Words -

For those of you who have children, and don't know it, we have a nursery downstairs.

- From a church bulletin -

And add to them, one of my favorites:

If I had known that grandchildren were so great, and so easy to raise, I would have had them first.

Now maybe I will be able to make you stop laughing with my next column.

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.

For Membership Questions or to Join ACOP

Contact Greg Leasure

greg@ACOPeds.org - (804) 565-6305

President's Message

Scott S. Cyrus, DO, FACOP
ACOP President

Unified Accreditation System

Scott S. Cyrus, DO, FACOP

Members of the ACOP, at the last meeting of the board in Las Vegas at the AOA OMED, a discussion of the ongoing issue of the Unified Accreditation System brought forth many questions and concerns, but few answers. The Board knows the issue will have great impact on our students, interns, residents and the future of the ACOP. Therefore, my President's Message is dedicated to this issue.

The Institutes of Medicine (IOM) recommended a unified accreditation process for graduate medical education programs across the nation. There are only two organizations that provide accreditation for postdoctoral training programs, the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA).

In 2011, ACGME announced proposed changes to its Common Programs, regardless of the program. These changes would restrict access to advance training positions. This means that ACGME would accept only ACGME residents in their fellowships. A DO completing an AOA accredited program, let's say in Pediatrics, would be prevented from being accepted into ACGME Neonatology fellowship. This obviously would limit access to our residents. The AOA, the AACOM and numerous other organizations negotiated with the ACGME to prevent this change in the Common Programs. The AOA and the ACGME are continuing to work together to negotiate a Unified Accreditation System.

As background, the ACGME is made up of five organizations: the American Medical Association, the American Hospital Association, the American Association of Medical Colleges, American Board of Medical Specialties and the Council of Medical Specialties Societies. The AOA accredits all of the DO programs.

The AOA has about 1,100 programs that train approximately 6,900 DO residents and interns throughout the nation. The ACGME has over 9,300 programs and trains more than 117,000 residents and interns, of which there are approximately 8,600 DOs. Some programs are dually accredited. Fifty percent of the osteopathic Family Practice programs, 80% of the pediatric programs and 30% of the internal medicine programs are dually accredited. Another interesting fact about the ACGME programs is that about 24% of the trainees are international graduates.

As most of you know, there has been a rapid expansion of the new colleges of osteopathic medicine. From 2002 to 2012, there were more than 18 new colleges added, either by new branches of existing colleges or creation of new locations, with 12 additional colleges in the pipeline. There has also been rapid expansion of class sizes in existing colleges. This has compounded the existing long-recognized problem that there are not enough AOA-accredited postgraduate training positions for our graduates. This makes us more dependent on the ACGME to train our COM graduates. In 2013, the AOA had approximately 2,900 funded first year postgraduate positions and graduated approximately 4,900 graduates. With that said, 56% of COM graduates are trained in ACGME Programs. I'm proud to report that the ACOP Graduate Medical Education committee has approved expansion of new postgraduate pediatric positions to help address this troubling issue.

The funding for the postgraduate medical education comes from the Centers for Medicare and Medicaid (CMS) and the IOM is calling for reform to the governance and finance of GME. Because of the call for reform, the AOA and the ACGME have external pressures to negotiate an equitable solution. The AOA entered into the negotiation with some core non-negotiable items. The negotiation would be for GME only, and not for licensure or other items. Specifically, the COMLEX exam given by the National Board of Osteopathic Medical Examiners (NBOME) would be recognized as the osteopathic preferred tool of examination; the process of board certification would continue to be under the control of the AOA and its specialty colleges; the identity and distinctiveness of osteopathic medicine would be preserved; there would be a level playing field for the our residents and our small community-based programs would be maintained.

As the negotiation progressed, the AOA and the AACOM agreed to pursue a single unified accreditation system with the development of a *Memorandum of Understanding (MOU)* with the ACGME. The AOA was persistent in communicating to the ACGME that the core issues were not negotiable. The negotiations concluded in July, and a *MOU* was delivered to the AACOM Board of Deans and the AOA Board of Trustees. In separate meetings both independently decided that they would not accept the *MOU* as currently written, because it did not adequately address the core principles.

At the AOA House of Delegates meeting in July, Boyd Buser, DO, AOA Board Trustee, gave an update on the progress that the AOA and the ACGME had made and the *Memorandum of Understanding (MOU)*. I appreciate the efforts that Dr. Buser has put forth on behalf the AOA Board of Trustees and the profession.

The ACOP and the AOA are working diligently to create new GME programs to provide superb training sites for our COM graduates. New programs, such as those in Columbus and Oklahoma, have created multiple pediatric positions. I applaud the hard work by both institutions. Most of the new positions have come from the creation of new programs in hospitals and health facilities that have not had previous Medicare funding, the so called "virgin" hospitals. These sites have the potential for providing GME training for our graduates. There are numerous areas around the country that can potentially serve as a GME training site that are unknown to the ACOP or the AOA. Over the past year there has been a 10% increase in AOA-approved GME positions. The ACOP GME committee can serve as a conduit to help create new GME positions and programs.

The negotiations are ongoing, with the idea of a unified accreditation system wanted by all parties, but for the AOA, not at the cost of our core principles.

According to the AOA website in October, the ACGME has delayed the implementation date of the revised Common Program Requirements for one year until July 2016. Also Fellowship pro-

Continued on page 11

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.

Eating Disorders: A Case Study

By Jessica S. Castonguay, DO, MPH

A 15-year-old female that has not been seen in the office for two years presents with a complaint of syncope. This happened at home yesterday. She was sitting in the kitchen, stood up and became dizzy. She fainted, striking her forehead on the chair. She reports mild headache only. Of note, this is the third time she has fainted in the last two months, first in church, then at a party. She admits to skipping breakfast on the days that she fainted.

Review of her chart shows a BMI of 26 at a weight of 160 pounds two years ago. Today her weight is 112 pounds with a BMI of 19.9. She has no chronic illnesses, she is on no medications and her immunizations are up to date.

On exam, HR is 70, RR 14, BP 107/75. BMI is 19.9, which is at the 46th percentile for age. LMP five months ago.

Orthostatic Vital Signs:

- Supine HR 50, BP 108/74
- Erect HR 84, BP 90/70

Pertinent Exam Findings:

- HEENT: Dry, cracked lips with tacky mucus membranes.
- CV: cap refill three-four seconds distally, three seconds centrally, ¼ dorsalis pedis and radial pulses
- Abdomen: palpable stool on left
- Extremities: cold hands and feet with purple hue, reticular pattern on lower legs and forearms
- Skin: fine hair noted to shoulders and upper back.
- POC: urine positive for ketones and specific gravity is >1.030. POC: glucose 75

Given her examination and laboratory findings, I was very suspicious of an eating disorder in this patient. Further questioning revealed that she began restricting nine months prior to the current visit because she felt fat. Her daily food allowance was 500 kcal. Her weekly workouts totaled between 20-25 hours. At her current weight, she continued to feel fat and felt as though she did not deserve to eat. According to the diagnostic criteria in the DSM-V, this young lady has anorexia nervosa.

I use this case to illustrate several points. First, not all eating disorders present with an underweight patient. This young woman, although having a normal BMI, was starving. In fact, patients with bulimia nervosa and binge-eating disorder tend to be normal weight, overweight, or obese. We do these patients a disservice by delaying treatment until they are underweight.

Second, with all the focus on the obesity epidemic, it is easy just to tell our overweight patients to "keep it up" when they have lost a few pounds. We are busy and being asked to see more and more patients. I urge you to take a few minutes and follow that up with questions about how they are losing the weight. Research has shown that the sooner a patient begins treatment after the onset of eating disorder behaviors, the higher the change of remission from the disorder.

Third, this patient presented with syncope, likely secondary to orthostasis due to her chronic dehydration and malnutrition. Her body just couldn't keep up anymore. Her vitals are concerning. Without the introduction of a regular intake of food and fluid on a regular basis, she would quickly need inpatient medical care. Bulimic patients can have severe electrolyte derangements from the abuse of laxatives or persistent self-induced vomiting. Eating disorders have the highest mortality of any psychiatric diagnosis, likely in part to the medical complications that can occur as a result.

Lastly, eating disorders are common. Anorexia nervosa is the third most common chronic illness among adolescent females in the United States. About 25% of all anorexia diagnoses are in male patients. And the gender gap closes if we consider binge behaviors. Diagnosis of anorexia and bulimia occurs most often in the mid-to-late teens.

So to all my general pediatric friends out there, if you practice long enough, you will have a patient with an eating disorder. If your residency training was like mine, you may not have had much experience with this population. It might make you really uncomfortable. If you are suspicious for these types of behaviors, trust your instincts. Ask the questions. Refer for an evaluation by a psychologist, eating disorder physician, or registered dietitian in your area. And if all else fails, you know where I work…you can find me.

Common Presenting Concerns to Primary Care:

- Amenorrhea
- Reflux/regurgitation
- Constipation
- Bradycardia
- Syncope
- Dehydration
- Hypoglycemia

For more information please visit **www.nationaleatingdisorders.org** and click on the LEARN tab.

EDITOR'S CORNER
Comments & Updates from our Editor

OMT and Pediatrics

By Robert Locke, DO, MPH, FACOP

Two recent articles by Italian Osteopathic researchers explore somatic dysfunction and interventional use of OMT in hospitalized premature infants. Francesco Cerritelli, DO, MPH, and colleagues evaluated the "Effect of osteopathic manipulative treatment on length of stay in a population of preterm infants: a randomized controlled trial" in BMC Pediatrics (open access/free at **http://www.biomedcentral.com/1471-2431/13/65**). In the OMT interventional arm there was reduction in the length of stay by six days. No adverse effects were noted. The mechanism of success was not directly studied. The authors hypothesize that the manipulative treatments were successful though improved physiologic stability permitting the earlier discharge. The economics in the Italian health care environment were favorable for OMT use in the NICU. There have been no similar studies in the United States.

Readers may appropriately be skeptical that a twice weekly 20-minute OMT evaluation and intervention is actually causative in reducing length of stay by six days given the complex milieu of the NICU environment and the ongoing applications of ongoing multiple competing clinical aspects designed interventions to improve outcomes while reducing length of stay. The use of randomized double-blinded control study design provides reassurance that the study results are valid. Further investigation is warranted. Consideration of whether non-educated touch and specific OT/PT support improves physiologic stability is a source of current investigation in the U.S. An osteopathic training institution is well suited to adding a third arm evaluating OMT-specific interventions.

These physicians also present a descriptive study of cranial and somatic dysfunction in preterm infants in a recent article in the JAOA (**http://www.jaoa.org/content/113/6/462.full.pdf+html?sid=fa487acf-e679-49e5-a13d-c1b6670ffc5a**) entitled, "Osteopathic Evaluation of Somatic Dysfunction and Craniosacral Strain Pattern Among Preterm and Term Newborns" (June 2013).

There are seven active osteopathic research institutes in Europe. There is active research ongoing in Europe to evaluate osteopathic medicine interventions. One such example institution is the European Institute for Evidence Based Osteopathic Medicine. You can read more about this organization through this link: **http://www.ebom.it/page/en/mission**. In Italy, where this research was performed, osteopathic medicine is not officially recognized.

ATTENTION! ALL RESIDENCY PROGRAM DIRECTORS

PULSE would like to highlight your program. Please send in information on your program, application process, activities, photos, etc. to **ACOPublications@gmail.com**.

NIH Providing a Home for Osteopathic Physicians

By Robert Locke, DO, MPH, FACOP

The National Institute of Health's (NIH) famed complex is the world's largest and most sophisticated research center. Many osteopathic physicians have found a clinical, research and administrative home at NIH. The most distinguished osteopathic NIH physician was Murray Goldstein, DO, MPH. Dr. Goldstein was the first osteopathic physician to serve as the Assistant Surgeon General of the United States Public Health Service and as an Institute Director. An NIH physician and researcher for over 40 years, Dr. Goldstein was the Director for the National Institute of Neurologic Diseases and Stroke, the government's leading institution for brain research.

The NIH can provide a wonderful career and life-experience for us ordinary physicians not operating in the stratosphere. "Don't be afraid", states Todd Wilson, DO, who is a NIH researcher, in an article in the *DO Magazine* (July, 2013) imploring osteopathic students and physicians to explore opportunities at NIH.

At the beginning of my career, I worked at the NIH. The dynamic and intellectual NIH environment remains a cherished part of my medical career and an ongoing academic reference point. The *DO Magazine* recently highlighted several talented osteopathic physicians who are currently at the NIH (**http://www.do-online.org/TheDO/?p=145021**). There are many wonderful opportunities for young physicians seeking an academic or research-based career.

Like Dr. Wilson, I encourage you to challenge yourself. Check out the multitude of opportunities at the NIH for young physicians. It's fun, rewarding and a unique life experience that can positively change your career.

In the JOURNALS

ACOP Members in Print

Robert Locke, DO, MPH,, FACOP and colleagues.
Work of Breathing Indices in Infants with Respiratory Insufficiency Receiving High-Flow Nasal Cannula and Nasal Continuous Positive Airway Pressure
J Perinatol 2013 Sep 26. doi:10.1038/jp.2013.120.
[Epub ahead of print] (Prior to publication, this was presented as a poster at an ACOP CME meeting.)

Robert Locke, DO, MPH, FACOP and colleagues.
Effects of Pre-Pregnancy Obesity, Race/Ethnicityand Prematurity
Matern Child Health J. 2013 Jun 26 [Epub ahead of print]
(Prior to publication, thiswas presented as a poster at an ACOP CME meeting.)

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

Welcome New Members!

Resident

Brittany E. Carey, DO ..... Brick,NJ
Jane Germano, DO ..... Brooklyn, NY
Nelli Gluzman, DO ..... Morganville, NJ
Sara Kane, DO ..... Jackson, NJ
Jubin Mathews, DO ..... Pembroke Pines, FL
Saloni Paudel, DO ..... Corpus Christi, TX
Jennifer T. Potonia, DO ..... Corpus Christi, TX
William Thomas II, DO ..... Danville, PA
Peta-Gaye K. Whyte, DO ..... Somerdale, NJ
Avery Wright, DO ..... Corpus Christi, TX

Intern

Ali H. Amad, DO ..... Miami, FL
Katherine A. Bonds, DO ..... Broken Arrow, OK
Anjali Chaudhari ..... Tulsa, OK
Christine Krier, DO ..... Corpus Christi, TX

Pediatric Student Club

Ekene E. Aguh ..... Duluth, GA
Dina Albasee ..... Prestonburg, KY
Andrew M. Alton ..... Aurora, CO
Samantha K. Anderson ..... Duluth, GA
Vignesh A. Arasu ..... Pikeville, KY
Natasha R. Avova ..... Suwanee, GA
Lynden J. Baesch ..... Erie, PA
Heather N. Barhorst ..... Pikeville, KY
Amanda H. Beach ..... Parker, CO
Amar M. Bhagat ..... Pikeville, KY
Sean M. Boaglio ..... Longview, WA
Nevin P. Body ..... Erie, PA
Grace E. Borton ..... Parker, CO
Michelle R. Boylston ..... Biddeford, ME
Alicia J. Brown ..... Erie, PA
Mitchel W. Brown ..... Westminster, CO
Dreisbach L. Brulez ..... Okemos, MI
Melanie L. Burnett ..... Duluth, GA
Cassandra R. Busler ..... Erie, PA
Krishan S. Chaddha ..... Biddeford, ME
Brian J. Chaffin ..... Pikeville, KY
Emily H. Chang ..... Atlanta, GA
Jenna X. Cheng ..... Erie, PA
Sudipa Chowdhury ..... Germantown, MD
Vanessa M. Clendenin ..... Englewood, CO
Kirstie R. Clune ..... Biddeford, ME
John T. Cochrane ..... East Lansing, MI
Brea D. Collins ..... Miamisburg, OH
Chelsea E. Copi ..... Okemos, MI
Seth A. Courson ..... Lawrenceville, GA
Rachel A. Courtney ..... Pikeville, KY
Bhuvaneshwari Dakshinamoorthy ..... Erie, PA
Joel C. Daley ..... Pikeville, KY
Neda Daneshvar ..... Voorhees, NJ
Linda M. Daniel ..... Englewood, CO
Kelly E. Davis ..... Boulder, CO
Rachel M. Denny ..... Rochester, MI
Kara V. Dickey ..... Aurora, CO
Ashley M. DiSipio ..... Rochester Hills, MI
Zachary R. Drennan ..... Aurora, CO
Leah M. Dunville ..... East Lansing, MI
Moriah Eberhard ..... Parker, CO
Abdelkhalek K. Elagamy ..... Kansas City, MO
Rachel L. Feinauer ..... Pikeville, KY
Christina M. Feldpausch ..... Port Crane, NY
Julia V. Fink ..... Buford, GA
Michael P. Flannery ..... Troy, MI
Denis M. Folan ..... Denver, CO
Peguy O. Gaboton ..... Lansing, MI
Gregory B. Galvin ..... Rye, NH
Ian Garrahy ..... East Greenwich,RI
Laura E. Gibbons ..... Parker, CO
Gregory B. Giles ..... Lawrenceville, GA
Daniel J. Goldbach ..... Erie, PA
Annamarie E. Goldstein ..... Pikeville, KY
Jasmine T. Gray ..... Lexington, KY
Kaitlan E. Groebli ..... Dacula, GA
Bianca E. Hall ..... Voorhees, NJ
Alysse Harb ..... Stevensville, MI
Jane E. Harness ..... Okemos, MI
Nicole J. Hartmann ..... Voorhees, NJ
Sarah A. Harwood ..... Grosse Isle, MI
Laubna N. Hatem ..... Pikeville, KY
Juliana S. Heimur ..... Voorhees, NJ
Tekesha T. Henry ..... Suwanee, GA
Joshua A. Hertel ..... Erie, PA
Travis R. Hoffman ..... Pikeville, KY
Melissa S. Holland ..... Pikeville, KY
Darvel E. Hutchinson ..... Duluth, GA
Andrienne M. Ide ..... Parker, CO
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Neel S. Iyer ..... Erie, PA
Aileen C. Johnson ..... Parker, CO
Sumalya Y. Kabir ..... Erie, PA
Betsy M. Kadapuram ..... Biddeford, ME
Renee G. Keefe ..... Erie, PA
Melissa M. Keslar ..... Suwanee, GA
Erika A. Kettelhut ..... Pikeville, KY
Lyndsey M. King ..... Pikeville, KY
Kyle D. Kopatich ..... Pikeville, KY
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Irene Lakhiani ..... Voorhees, NJ
Rakhee Lalla ..... Princeton, NJ
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Hematheja Lanka ..... Lawrenceville, GA
Lindsay R. Lawrence ..... Aurora, CO
Han N. Le ..... Cinnaminson, NJ
Jason A. Levine ..... Erie, PA
Paige N. Lewis ..... Pikeville, KY
Ann E. Libbert ..... Henderson, KY
Brendan Mahow ..... Haddenfield, NJ
Lauren E. Matera ..... Westmont, NY
Daniel J. McCarty ..... Pikeville, KY
Sean P. McGowan ..... Lakewood, CO
Ariel M. McKenna ..... Billerica, MA
Jaclyn T. Miettinen ..... Troy, MI
Caitlin J. Miller ..... Aurora, CO
Sarah E. Miller ..... Englewood, CO
Tyler A. Mineo ..... Lawrenceville, GA

Welcome New Members!

Megan A. Moscariello	Englewood, CO
Tracy Nagle	Okemos, MI
Mimi T. Nguyen	Pikeville, KY
Emily A. Niemyjski	Okemos, MI
Kara L. Oliver	Erie, PA
Enh M. O'Neill	Pikeville, KY
Caitlin C. Panter	Pikeville, KY
Reena Patel	Lawrenceville, GA
Rhumit Patel	Lawrenceville, GA
Yuliya Pepelyayeva	Okemos, MI
Matthew J. Petruso	Pikeville, KY
Molly E. Philbin	Erie, PA
Monica P. Pinglo	Tucker, GA
Mia Pivirotto	Biddeford, ME
Kristin N. Powell	Denver, CO
Cherah J. Pryce	Pikeville, KY
Deepika Ram	Erie, PA
Hollis D. Redmon	Lindenwold, NJ
Megan A. Richards	Atlanta, GA
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Brian T. Robertson	Pikeville, KY
Christopher J. Rogers	Biddeford, ME
Eli R. Sager	Okemos, MI
Amanda L. Schmidt	Englewood, CO
Lauren M. Schmittle	Erie, PA
John Scholz	Biddeford, ME
Emily M. Scott	Pikeville, KY
Vinay G. Setty	Parker, CO
Shalini H. Shah	Biddeford, ME
Meenu Sharma	Lawrenceville, GA
Valene P. Sherner	Lawrenceville, GA
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Tiffany N. Simon	Duluth, GA
Charles T. Simpkin	Englewood, CO
Leah C. Spungen	Erie, PA
Alyssa M. Stapf	Erie, PA
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Frederich A. Stine	Pikeville, KY
Jaclyn M. Stuekerjuergen	Parker, CO
Amanda R. Sturgill	Pikeville, KY
Kanya Sughapakdi	Duluth, GA
Amanda Sukhu	Central Islip, NY
Katelyn M. Sullivan	Milton, MA
Katherine M. Tadros	Suwanee, GA
Whitney A. Taylor	Fort Worth, TX
Daniel Torrens	Suwanee, GA
Deepa R. Voleti	Pikeville, KY
Jonathan M. Walrath	Pikeville, KY
James W. Watkins	Parker, CO
Eleni M. Weisnicht	Denver, CO
Larissa A. Wertalik	Erie, PA
Angela C. Whiten	Duluth, GA
Rachel N. Willimann	Pikeville, KY
Yubo Wu	Northville, MI
Timothy Yang	Erie, PA
Danielle Z. Zachar	Erie, PA
Michael J. Zalenski	Erie, PA

2013 Pediatric Track Winning Posters

Congratulations to the poster winners in the Research and Case Study categories!

Dr. Scott Cyrus (right) accepts the Best Research Award from Research Committee Chair Dr. Erik Langenau (left), on behalf of his colleagues.

RESEARCH POSTER WINNER

"Cowboys Get Healthy, Get Fit" A Medical Community Program for Healthy Lifestyle Changes in Overweight & Obese Children – Outcome Analysis of BMI, Aerobic Fitness, and Lifestyle Behaviors

Binh Phung, DO[1]; Colony Fugate, DO[1 & 2]; Sara Malone, MS, RD/LD[2]

[1] Oklahoma State University Department of Pediatrics, Tulsa, Oklahoma; [2] Oklahoma State University Family Health & Nutrition Clinic, Tulsa, Oklahoma

CASE STUDY POSTER WINNER

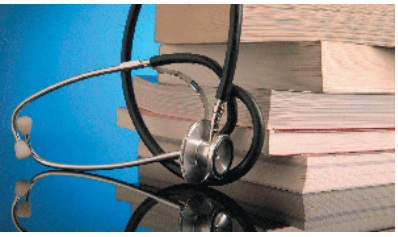
Unresponsive Eosinophilic Esophagitis in a Pediatric Patient with Common Variable Immunodeficiency

Erin C. Toller-Artis, DO; Kathryn Wessel, DO; Devi Javari, DO; Julie Sterbank, DO; Jonathan Horbal, DO; Haig Tcheurdjian, MD; Robert Hostoffer, DO

University Hospitals, Richmond Medical Center, Conjoint Allergy/Immunology Fellowship, Allergy Immunology Associates Inc., Cleveland, OH

Dr. Erik Langenau (right) presents the Best Case Study Award to Dr. Robert Hostoffer, Jr. (left) and his colleagues.

Osteopathic Education



What Does It Mean to be An Academic Pediatrician? One Woman's Tale.

By Tami Hendriksz, DO, FACOP

For me, it means having the most ideal blend of clinical and classroom work.

I love my job. Truly. I realize how fortunate I am; not many people can say that and mean it. Being a pediatrician is one of the most rewarding careers that a person could have – followed closely by being an educator. In my job, I get to do both. Most days I feel like I make a positive difference in the lives of my patients, their families and my students. It is an incredible honor to be able to help people in these capacities.

In the one setting, I have the glorious opportunity to help a sick child get better, support a family as they struggle with a challenging diagnosis, help a special needs child find the services that will benefit the child, watch a newborn baby grow and develop into a stumbling toddler and then a mature child, and so much more. It's miraculous and inspiring work. In the other setting, I am an assistant professor delivering lectures to 135 medical students at a time on topics ranging from pediatric neuromusculoskeletal disorders to shock and sepsis. In that role, I also run and assist in laboratory settings where we teach students how to use their medical instruments, physical diagnosis skills, clinical reasoning, presentation skills, the art of developing an excellent differential diagnosis, and so much more. I serve as coordinator of courses, student advocate, advisor, and mentor. The idea that I am helping to shape our future osteopathic physicians is powerful and enthusing.

These two parts of my job complement each other very well. Working with students makes me a better practicing physician. I feel an urgency to stay on top of the current literature, and be very knowledgeable about the best practices and techniques. Additionally, the more I practice, the more experience and cases I have to share with my students. This adds a different emphasis, more variety, and an authenticity to my lectures and teaching. It is an added benefit that I alternate my days during the work week: one day I am in clinic, the next I am on campus, and so on. In this way, if I ever get frustrated or fed up in one particular setting, I know that the next day will bring respite to that venue.

To top it all off, I also get to write articles for journals and newspapers, advocate for students and pediatric patients, go to conferences with other intelligent and motivated pediatricians to further my education and expand my views, and most recently, serve as an associate editor for the ACOP *eJournal*. If variety is the spice of life, then my professional world is "muy caliente." And that's just how I like it. The busier I am, the more productive I am – up until that dangerous tipping point, which I am forever trying to avoid.

I certainly do not mean to give the impression that there are zero negatives about my job. Quite frankly, I could do without the higher education bureaucracy, the endless forms, the electronic health record nuances and malfunctions, the room conflicts, and a lot of the "other" aspects of my job that don't involve directly dealing with patients or students. However, to complain or find fault in the small stuff only distracts from the great work and minimizes the honor of this profession. If I didn't love my job so much, I would be at home - where I have an equally (if not more so) important, challenging, rewarding and amazing "job" of raising my two young children. For the time being, I choose to continue to try to balance it all. Pediatrician, medical educator, writer, editor, advocate, mother, and more.

Tami Hendriksz, DO, FACOP, FAAP is the mother of two gorgeous, and rambunctious children. She also works as an assistant professor of medicine at Touro University College of Osteopathic Medicine. There, she serves as a course coordinator for multiple subjects, the co-coordinator of the third year core pediatric rotations and most recently as the vice-chair of the primary care department. Dr. Hendriksz also serves as chair of the ACOP Communications Committee, co-associate editor of the ACOP eJournal and frequent contributor to the PULSE.

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Reflections by Past Presidents of the ACOP

Edited by Steven Snyder, DO, FACOP

By Thomas F. Santucci, DO, FACOP, FAAP

Thomas F. Santucci, Jr., DO, FACOP, FAAP (ACOP President: 1981-1982)

I was pleasantly surprised to receive an email from Steve Snyder asking me to write an article for a new PULSE feature regarding the perspective and reflections of past ACOP Presidents including their major successes, struggles, opportunities, triumphs, and failures. It shook my memory of a time over 30 years past and tested my recall. I was grateful for the superb acopeds.org website as an excellent resource to jog my memory. I enjoyed perusing Robert Bomboy's *The Golden Anniversary History of the ACOP, 1940-1990* that brought back many fond memories of my association with the organization and my respected colleagues, both peers and predecessors.

My first recollection of an ACOP Presidency was as a twelve-year-old in 1954 when my father was installed as President at the Royal York Hotel in Toronto, Canada. I suspect that this was not my first time at the ACOP Annual Meeting, but the first where I recall attending an event. Bomboy's history captured who my Dad was with quotes from my "Uncle Arnold" (Arnold Melnick) and my dear peer, Ella Marsh. Their words confirmed that I am my father's son. In my youth, the Santucci family travels, with rare exception, included an annual trip to the ACOP meeting, as was the case with many other families of DO pediatricians. My three daughters reminisce about their attending many annual ACOP meetings. With my Pop's lifelong professional commitment to osteopathic pediatrics, it is not surprising that the first 50 years of my life were intertwined with the ACOP, so I shall reflect on my career service to the ACOP.

As a "congenital osteopathic pediatrician," it was no surprise that I followed in my father's rather large footsteps; although it was not in my admission interview for PCOM in 1963. I was amazed when asked, "Why do you want to be an osteopathic physician?" Needless to say, I was fully aware of the challenges that faced those of us pursuing a career in healthcare within a "minority profession." I mention this because it is relevant to answering questions Steve posed for me to answer in this article, as were several academic and clinical experiences during my osteopathic education. In those days, a DO faced similar bias to any minority ethnic and religious groups. We faced discrimination and scrutiny as non-MD physicians. Arnold Melnick referred to this prejudice in his "Reflections" article in a recent issue of the PULSE. I found this prejudice a tremendous motivation to excel personally and, as an extension, to enhance the profession. It became a driving force in my professional life and organizational endeavors, including the ACOP, AOBP, National Board of Osteopathic Medical Examiners (NBOME) and also in my academic appointments at COMS, MSU-COM and UMDNJ-SOM.

I wanted to make a difference and directed my efforts in two venues, education and credentialing. In order to be accepted in the healthcare world, I believed that the osteopathic profession needed to improve its educational systems and have valid credentialing processes beyond reproach on scrutiny by outside institutions. I became a member of the ACOP upon entering my pediatric residency in 1968 at the Grand Rapids Osteopathic Hospital under the superb tutelage of Leo Wagner and Patricia Cottrille, strong advocates of the College.

In 1974, ACOP President Ben Cohen asked me to be the Program Chairman for the ACOP 1975 Annual Meeting in Williamsburg, VA with the charge of improving the level of the educational meetings. As quoted in Bomboy's history, "We were able to get some funding and we developed a different format, so we went from programs that were slipshod to something that was well-planned with top notch speakers." With deference to earlier meetings, we secured some serious funding from several pharmacological companies, especially Ross Lab and Mead Johnson. As described in Bomboy's history, the four guest MD speakers were nationally and internationally acclaimed. Each speaker had a day of the program into which we blended our own people who presented case problems that promoted a dialogue with the attendees. An important aspect of the program was that it exposed our prestigious speakers to our group and I think it did much to enhance their opinion of osteopathic pediatrics. Bomboy wrote that the Williamsburg program became a benchmark and then year after year, every program chairman felt obliged to "live up to Santucci." I was pleased that Joe Dieterle mentioned this in his "Reflections" article in the PULSE. Although not during my Presidency, I consider this a significant accomplishment that has been perpetuated by the ongoing quality CME offered by the ACOP.

Upon becoming President in 1981, I was fortunate that approximately two weeks earlier, the ACOP hired a new Executive Director, George Degnon, who was superbly qualified for the position. We developed a working and personal relationship that enabled my tenure to be very productive in fulfilling my inauguration pledge to pursue and improve relations with American Academy of Pediatrics (AAP). This had been initiated during Ben Cohen's term as ACOP President in 1974. I was able to boost it through George Degnon's relationship with the AAP and Ross Lab through Len Fries funding travel expenses. I met with the AAP President and Executive Director in Kansas City, MO. We developed a relationship and the AAP President accepted my invitation to attend our annual meeting in 1982. A quasi-formal relationship was established with the AAP and successfully pursued by subsequent ACOP administrations. I celebrated the culmination of all their efforts in 1998 by becoming a "Fellow in the American Academy of Pediatrics (FAAP)." With George Degnon, other accomplishments during my term included reinstatement of a newsletter, procurement of additional outside support for the annual meeting, a new membership directory and improved attendance at the annual meeting.

Beyond improving osteopathic pediatric education, I was concerned about the validity of our profession's credentialing processes that lead me to become involved in the AOBP and NBOME. My concern regarding the AOBP was triggered by my own written and

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FYI STAY IN THE KNOW!

Recommendation Reminders

Recommendation: The AAP has made two recommendations: Check children's weight for length from birth to 18 months of age and check Body Mass Index (BMI) from 24 months of age through adolescence.

Comment: Perhaps these two suggestions would be more easily remembered as a single thought: Evaluate the child's weight for length at every visit from birth to 18 months of age and thereafter do a Body Mass Index (BMI) at every visit.

Recommendation: The American Academy of Orthopedic Surgeons recommends that children's backpacks should not exceed 15 to 20 percent of a child's body weight.

Comment: It has been known for some time that many youngsters carry heavier loads than this and a large number of them have been reported with serious back problems. According to the Consumer Product Safety Commission, 9,500 children sought medical help for backpack-related injuries in 2012. In addition to weight, how the weight is distributed in the backpack and the characteristics of the backpack help reduce injuries. See (**http://orthoinfo.aaos.org/topic.cfm? topic=a00043**) for additional information. Perhaps physicians should routinely include this in their histories of school-age children or as a regular reminder whenever a child comes to the office

Prescription Pads are Available to ACOP Members

These prescription pads can be used to deliver clear, consistent messages to your patients during the well child exam. This simple tool can help you get your patients and families to start making changes. You can help educate, motivate and encourage all patients to live healthy lifestyles.

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.

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Have questions about ACOP activities or want to become involved? Email Kim Battle at kim@acopeds.org for more information.

President's Message

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grams are allowed to select "exceptionally qualified applicants" who completed residency training in non-ACGME programs, including physicians who completed prior training in AOA-approved residency programs. Individual Residency Review Committees are allowed to grant exceptions at the fellowship level and not require that prior residency training has been completed in ACGME or Canadian programs. Interestingly enough, the ACGME Board did not approve the proposed language that would have given physicians with residency training in ACGME international programs the same status as physicians with ACGME or Canadian residency training.

The ACOP continues to monitor the situation as it unfolds and will provide you with the most up-to-date information. One of the ACOP Board concerns for our students that might want to pursue an ACGME residency or fellowship is the taking of the USMLE. As it stands now, the COMLEX is the examination that is required for all osteopathic students. Most, if not all, ACGME programs don't recognize COMLEX as an examination for entry into ACGME programs. At this time, the ACOP Board recommends that students should seriously consider taking both the COMLEX and the USMLE to provide ample opportunity for their postgraduate training. The Board understands this adds significant time and financial resources to student's already mounting medical educational expenses, but we feel it will give you the best opportunity to pursue all avenues of pediatric GME. In my personal experience, I was confident that primary care pediatrics was final destination in my GME and that I could obtain a high quality osteopathic residency training position. Therefore, I chose not to take the USMLE.

The climate of GME has forever changed and the ACOP is taking an active role in monitoring the situation to give to you the best information so as your students become interns and residents and proceed onto fellowship, they will have the best education to serve humanity to the highest degree.

May your upcoming Holiday Season be safe and bright and remember to register for the ACOP Spring Conference in Kansas City in April. We'll see you in the springtime and have some barbeque.

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oral certification examination.

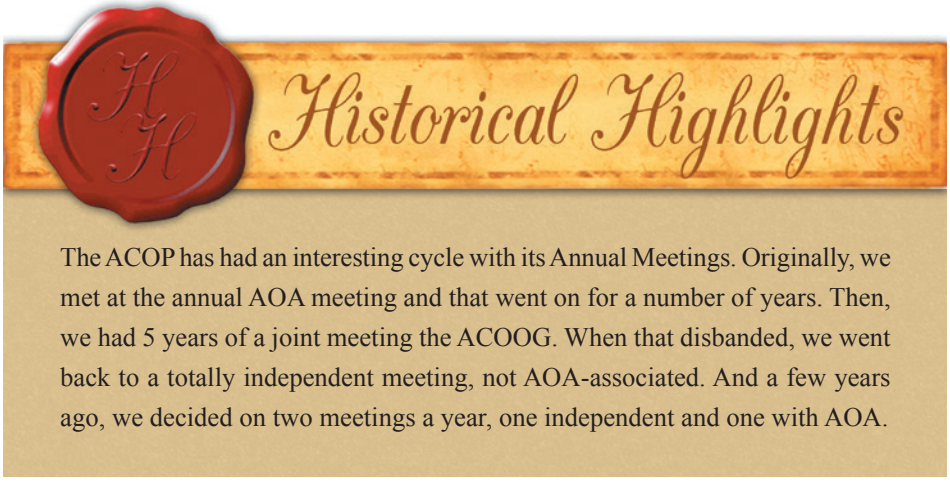
The written examination was not balanced to test the many disciplines of general pediatrics. For example, my fellow examinees and I felt that over 15% of examination tested parasitology to the exclusion of other areas. Following election to the AOBP in 1980, I reviewed the written examination and it was apparent that it lacked a test blueprint. The AOBP corrected that deficiency by developing a basic test blueprint of which a highly refined version appears today in the *AOBP Application Handbook* as the "General Pediatrics Examination Questions Categories".

The AOBP faced challenges during this time. In the Fall 2012 PULSE, Joe Dieterle wrote, "Most frustrating for me was the inability to get the American Board of Pediatrics to administer subspecialty board examinations to DO's who completed DO residencies and went on to train in MD subspecialties (neonatology, pulmonary, infectious disease and cardiology, to name a few). To this day, I believe this problem still exists."

Upon completing my term as President in 1982, I served as Chair of the AOBP Test Construction Committee. Along with Neil Kantor, Dennis Hey, Mike Ryan and others, an ad hoc committee was established to construct a subspecialty board in neonatology. We gathered several thousand questions including those submitted by candidates, plus many more questions solicited from MD neonatologists who had trained DOs. Funds were limited and "on a shoestring," we held a test construction meeting at UMDNJ-SOM in Camden where I was Pediatric Chairman. To save money, the committee members literally bunked in at the homes of Mark Jacobson, Marty Finkel and me. Our efforts resulted in the AOBP administering its first subspecialty examination in 1985. I consider it a major milestone for the AOBP, as well as a personal accomplishment, comparable to those with the NBOME. It was especially important to me because I had several residents who completed neonatology fellowships and were adversely affected by the lack of a certifying examination including Mike Musci, Paul DeFranco, Rob Locke, Barbara Ianni, Barbara Russell and others who escape my aging memory.

I appreciated Joe Dieterle's statement regarding the lack of AOBP subspecialty Boards, especially pulmonary. I completed a sabbatical/fellowship in pulmonology in 1988 at Duke University Medical Center and the training was approved by the AOA (thanks in a large part to Joe Dieterle) in 1989. Some 17 years passes, and in November 2006, I had the opportunity to sit for the AOBP's first subspecialty examination in pulmonology along with my former resident, partner in pediatric pulmonary practice and close friend, Joe Salvia. We both commend the AOBP for establishing a challenging and comprehensive examination process. At the age of 64, I became certified in pulmonology. I consider this a significant achievement and a tribute to the tenacity of both the AOBP and us.

Well, this is probably more Reflections than Steve, Rob and Uncle Arnold had anticipated in this new feature. I hope it provides the younger ACOP members a perspective on how far they have taken the College. Congratulations to the ACOP on what it has become and best wishes on its continued growth.



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