



The New Jersey Pediatrician

Volume 32 • 3rd Quarter 2007

Newsletter of the American Academy of Pediatrics/New Jersey Chapter

PCORE CORNER

(Pediatric Council on Research and Education)

*Steve Kairys, MD, Medical Director/Chair,
PCORE Board of Trustees*

Fran Gallagher, MEd, Executive Director

NJ Pediatric Council on Research & Education

We've Moved! NJ PCORE, the Foundation of the AAP/NJ, functions as the quality improvement arm of the AAP/NJ. While we are in a new space... we work to provide support and technical assistance to community pediatricians to help shape child health for the 21st Century.

In June, the PCORE Board of Trustees, several who are Board Members on the AAP/NJ Board of Directors as well, participated in a Board training and strategic planning meeting. Sleeves were rolled up to: update PCORE's mission, create a vision statement, rewrite the bylaws, and prioritize strategic plans. The new vision and mission statements approved by the Board of Trustees 6/07 are:

Vision

Shaping child health in New Jersey for the 21st century

Mission

The mission of PCORE, the Foundation of the American Academy of Pediatrics/NJ Chapter is to:

- Promote the medical home through public and private partnerships
- Catalyze linkages between healthcare providers, families, public partners and communities
- Improve systems of care in communities and healthcare practices
- Educate both pediatricians and families
- Promote comprehensive pediatric healthcare through public and private partnerships

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Report from the New Jersey Legislature

Nancy Pinkin, MPA, CHE

LEGISLATURE HEADS INTO LAME DUCK SESSION

The State Legislature heads into the lame duck session this fall. All 120 State Senate and Assembly members are running for re-election. Currently, New Jersey's governor is a Democrat. Democrats also control the Senate 22-18 and the Assembly 50-30. Districts 1, 2, 8 and 12 which state Democratic Chairman Joseph Cryan said appear to be the most competitive, and mostly Republican. In District 1, Democratic Assemblyman Jeff Van Drew is challenging Republican Sen. Nicholas Asselta; Republican Sen. James McCullough will face Assemblyman Jim Whelan for the Senate seat in District 2; Democratic Assemblyman Francis Bodine is running against Burlington County clerk Phil Haines for the Senate seat retired by Republican Sen. Martha Bark in District 8; Republican Assemblywoman Jennifer Beck is challenging Democratic Sen. Ellen Karcher for her seat in District 12. Over 17 legislators will not be running for re-election. As a result, the lame Duck session has the potential to be particularly difficult as exiting legislators try to pass favorite bills before they exit and they no longer have to answer to voters.

IMMUNIZATION REIMBURSEMENT LEGISLATION INTRODUCED IN THE SENATE AND ASSEMBLY

AAP/NJ has worked with Senator Joseph Vitale and Assemblyman Herb Conaway to seek legislative relief for adequate immunization reimbursement. **S2652**, sponsored by Senators Vitale and Diane Allen, and **A4182**, sponsored by Assemblyman Conaway, have been introduced and now await committee action when the legislature returns in the fall. The bills require health insurers, HMOs participating in Medicaid and NJ FamilyCare, to cover all childhood immunizations recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health and Senior Services, to ensure

appropriate reimbursement to health care providers that adequately covers their costs.

The bill directs the Commissioner of Health and Senior Services, in consultation with the Commissioner of Banking and Insurance, to specify by regulation: the minimum level at which a health insurer is to reimburse a health care provider for childhood immunizations to reflect the reasonable costs of acquiring, maintaining, and administering the childhood immunizations. Reimbursement would be determined by the Commissioner of Health and Senior Services after consultation with the American Academy of Pediatrics - New Jersey Chapter, the Medical Society of New Jersey and the New Jersey Academy of Family Physicians. The bill includes a civil penalty to against a health insurer that fails to comply with the requirements of up to \$1,000 for the first violation, \$5,000 for the second violation, and \$10,000 for the third and each subsequent violation.

GOVERNOR ADDS STATE BUDGET LANGUAGE TO INCREASE MEDICAID REIMBURSEMENT

Governor Jon Corzine included budget language in the New Jersey State Budget for Fiscal Year 2008 to increase Medicaid payments to pediatricians. On page D-188 of the State Budget FY2008, he "recommended \$5 million in growth to provide better medical care for New Jersey's most vulnerable children by increasing reimbursements to pediatric service providers. The fact that New Jersey has the lowest Medicaid reimbursement rates in the nation has created a barrier to accessing care. Increasing the funding for pediatric services as of **January 1, 2008**, will increase access to primary care services and result in fewer Medicaid resources being spent on expensive and less appropriate settings such as hospital emergency rooms.

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American Academy of Pediatrics



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3rd Quarter 2007

American Academy
of Pediatrics/
New Jersey Chapter
Established 1950

President's Message Janice Prontnicki, M.D, MPH, FAAP

New Jersey has a rich history of pediatricians who have done much for our profession and the children of our state. I am very fortunate to have known several of those who have dedicated themselves to making New Jersey pediatrics what it is today. They all deserve our respect and gratitude and I'd like to use this column to salute a few of our pediatric leaders.



Dr. Lawrence Taft is truly one of the great New Jersey pediatricians. For decades he dedicated himself to the Department of Pediatrics at Rutgers Medical School/ Middlesex General Hospital, which became Robert Wood Johnson/UMDNJ. Under his guidance, as Chairman, the department went from a handful of pediatricians to a full faculty, setting the stage for one of the outstanding children's hospitals in New Jersey today. I've had the pleasure of knowing Dr. Taft since the late 1980's. He is a dedicated family man who loves fishing and took up skiing and sailing. He is an excellent pediatrician, teacher and mentor. A true gentleman scholar in every sense of the word. His contributions to New Jersey pediatrics are innumerable. Thank you Larry!

There was a time when family practitioners provided the majority of child care in our state. Dr. Avrum Katcher was one of the first pediatricians to set up a pediatric practice in rural Hunterdon County. That practice has grown into one of the largest and most respected pediatric groups in our state. But after all his hard work- does Ave even think of retiring? From the practice maybe, but not from pediatrics. He continues to volunteer his time and experience through teaching at the medical school and chairing the AAP's National Section for Senior Members. He keeps active and enjoys gardening. Thanks for all you do Ave!

At this year's AAP/NJ Annual Chapter meeting in June we honored Dr. Wayne Yankus for his contributions to our chapter. Wayne has been active for nearly twenty years serving our chapter including as chapter President. He has been the Chair of our School Health Committee and under his leadership, the annual School Health Conference held each October has grown to a very successful meeting drawing over 500 attendees yearly. He is also active at the district level serving as our CATCH (Community Access to Child Health) coordinator for AAP administered grants. A former teacher, he brings a special perspective to pediatrics and especially to school health. Thanks Wayne for all you've done for our Chapter!

There are undoubtedly numerous other pediatricians whose efforts have been invaluable to our state. And of course whenever one is identified we risk leaving out many others. So feel free to send us your own memories of those who made our state what it is today. Or simply give them our heartfelt thanks- for all they do, every day.



Report from the New Jersey Legislature

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In recommending these funds, the Governor has reaffirmed his position to provide quality medical coverage for this most vulnerable population."

Since that time, AAP-NJ had a meeting with Commissioner Jennifer Velez and Kerri LoGosso, Health and Human Services Policy Advisor to the Governor, to discuss distribution of the funds. The State has long held the position that it does not mandate to HMO's how to allocate the funds it provides HMO's to deliver health-care services. They are able to use funding increases for any area of patient care services they choose to direct funding do. There have been interested parties among children's advocates who have been advocating for these funds to be allocated for dental services. AP-NJ is currently reviewing language used in other states to ensuring the amount allocated in the Governor's budget goes to those doctors caring for children. While we agree that dental care is important, these funds must go to raising reimbursement for physician services, as the Governor intended them to be used.

SCOPE OF PRACTICE LEGISLATION

AAP/NJ is working with the Medical Society of New Jersey and other medical specialty groups to protect the role of the physician. We are working to oppose or amend the following bills that seek to expand scope of practice for non-physicians:

CHIROPRACTIC

S2636 Sweeney (D3) / **A3122** Caraballo (D29); **Wisniewski** (D19); **Albano** (D1); **Prieto** (D32); **Van Drew** (D1) +10 permits revised methods of treatment for chiropractors and establishes continuing education requirements. The bill provides that a chiropractor may use any method of treatment of a patient, except the use of surgical cutting, so long as the methods of treatment or diagnoses or analysis were taught in any chiropractic college or post graduate course or approved by the chiropractic board. The bill further provides that a chiropractor may order, request, or prescribe generally recognized medical tests or provide dietary or nutritional counseling.

A4416 Caraballo / **S2871** **Karcher** (D12); **Lesniak** (D20) provides that practice of chiropractic includes diagnosis and adjustment of articulations of spinal column and other joints. Chiropractors seek to amend their current scope under this bill to state: "the practice of chiropractic is defined as follows: "A system of adjusting the

articulations of the spinal column by manipulation thereof." It is within the lawful scope of the practice of chiropractic to diagnose, adjust, and treat the articulations of the spinal column and other joints, articulations, and soft tissue structures clinically related to the spinal column and to order and administer physical modalities and therapeutic, rehabilitative and strengthening exercises." The Coalition has been meeting with bill sponsors regarding our opposition.

PHYSICAL THERAPY

A3790 Cohen /Stack/Panter/Vandervalk / **S2600** Doria / **Karcher** (D31); **Karcher** (D12) +3 provides that, for the purposes of third party reimbursement, a physical therapist is a specialty physician or specialist within the scope of the "Physical Therapy Licensing Act of 1983," P.L.1983, c.296 (C.45:9-37.11 et seq.), and may be referred to as a physical therapist physician except that a physical therapist shall not use the title, designation, words, letters, abbreviations, or insignia indicating the practice of medicine or surgery, or hold himself out by any means to be a medical doctor or doctor of osteopathy. The amendments also provide that a licensed physical therapist must refer a patient to a health care professional licensed to practice dentistry, podiatry, or medicine and surgery in this state if the licensed physical therapist during the examination, evaluation, or intervention has reason to believe that physical therapy is contraindicated or symptoms or conditions are present that require services outside the scope of practice of the licensed physical therapist; or if the patient has failed to demonstrate reasonable progress within 30 days of the date of the initial treatment. In addition, the amendments provide that not more than 30 days from the date of initial treatment of functional limitation or pain, a licensed physical therapist must consult with the patient's licensed health care professional of record regarding the patient's plan of care. In the event the patient has no identified licensed health care professional of record, the licensed physical therapist must consult with a licensed health care professional of the patient's choice. The amendments also delete provisions that deem a decision to reduce, delay, or deny a health care claim for reimbursement to be an allegation of physical therapy licensee misconduct, and that allow a claimant to appeal such a decision to the State Board

of Physical Therapy Examiners. The Coalition has been meeting with bill sponsors and the Physical Therapy Associations to negotiate changes to the bill.

ATHLETIC TRAINER

A 3259 Caraballo / **S2678** Lesniak / Carinale revises the "Athletic Training Licensure Act," by amending the definition of "athlete" to include an individual who participates in strenuous physical exercise, physical conditioning, or a sport. The bill also sets parameters on when a licensed athletic trainer may provide athletic training. The bill provides that a licensed athletic trainer may provide athletic training only: 1) to athletes engaged in interscholastic, intercollegiate, or intramural athletic activities which are being conducted by an educational institution licensed in this State; or to professional athletes; or 2) to athletes in any setting when the athletic trainer is under the supervision of a physician licensed in this State. The bill also adds a definition of "supervision," relative to this setting, which means that a physician licensed in this State must be accessible to an athletic trainer, either on-site or through voice communication during athletic training. While AAP/NJ is supportive of the work of athletic trainers, we have some concerns about the legislation related to the supervisory aspects of the relationship between the physician and the athletic trainer and have requested clarification of the supervisory role of the physician. We have also been reviewing the issue with the Board of Medical Examiners and bill sponsors.

FEDERAL SCHIP REAUTHORIZATION

AAP/NJ is working with AAP- National Office to advocate for the reauthorization of SCHIP funding. The Senate Finance Committee recently released its mark up of SCHIP legislation, and we have heard that the House Energy and Commerce Committee will do the same. Here is an overview from Claire Bornstein from AAP National of what we know so far about the Senate bill:

The Good News:

- The bill includes a strong comprehensive quality framework.
- It includes significant funding for outreach and enrollment.

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PCORE CORNER

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- Translate research into models of care and translate outcomes into improvements to those models of care
- Orchestrate improvement in health and social policies that affect all children especially those who are most vulnerable
- Provide pediatric expertise for systems of quality care for all children

Our programs reflect PCORE's vision and mission. See page 5 for the PCORE organizational flow chart. Please feel free to visit and to contact us to learn more about the many exciting programs and

cost-free opportunities for you and/or your practice team.

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The Foundation of the AAP /NJ
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www.njpcore.org

(watch our website expand this fall to include electronic workspaces for all programs!)

We continue to invite you to look over the many opportunities and think about how you would like to become involved... a few ways to become involved are:

- Board Membership
- Board Committee Membership
- Assisting with Trainings and Presentations as a Trainer
- Enrolling your Practice Team in a PCORE Program
- Becoming a Program MD Champion
- Making a Tax Deductible Donation to PCORE (501 c 3)

The PCORE team looks forward to working together with you on behalf of New Jersey's children and their families... as we work to shape child health in New Jersey for the 21st century!



PCORE®

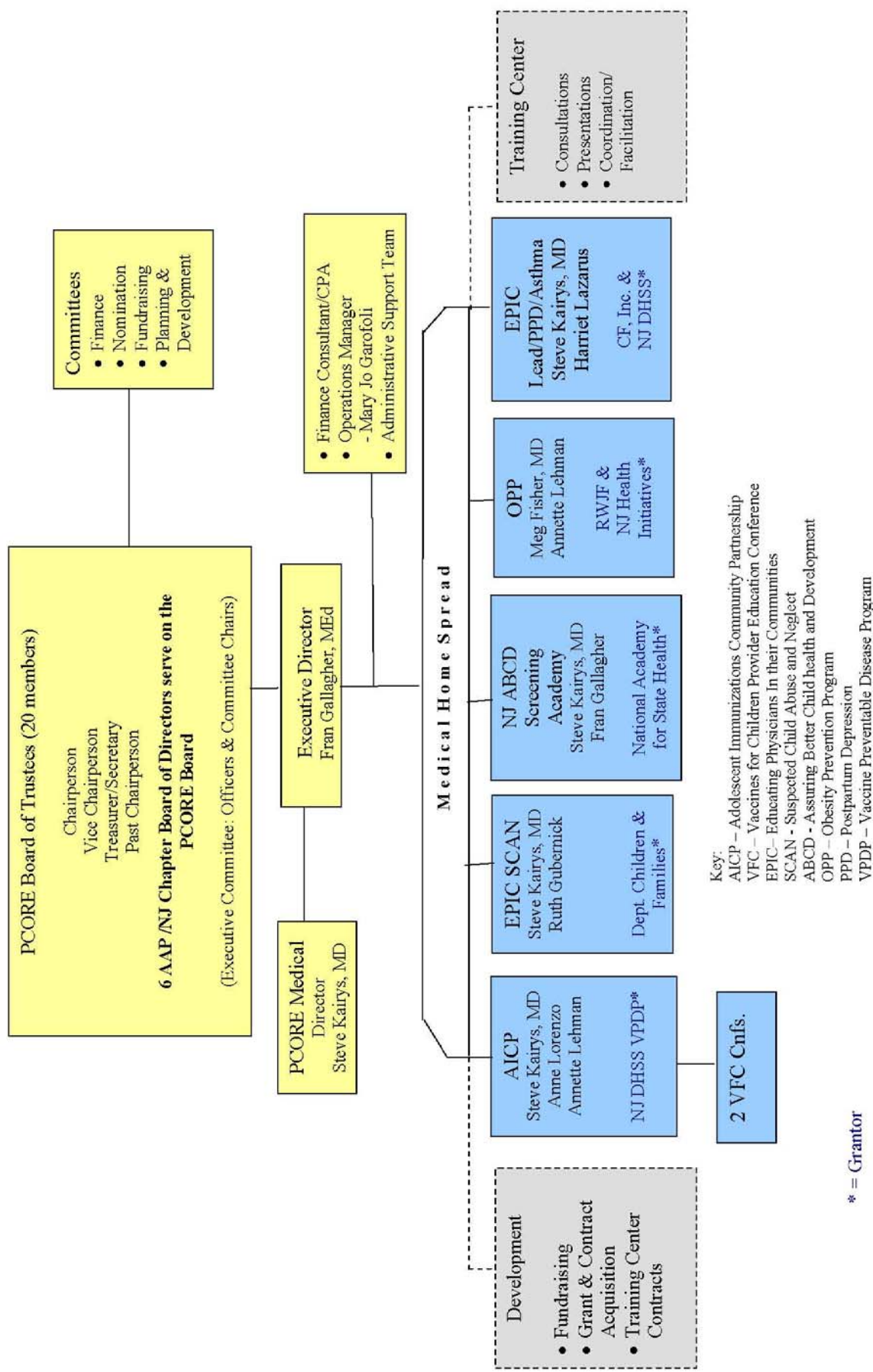
Pediatric Council on Research & Education

Foundation of the American Academy of Pediatrics / NJ Chapter



We Have Moved!
Please visit us at our new central office:

3836 Quakerbridge Rd., Suite 108
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Report from the New Jersey Legislature

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- Children below 300% of the FPL will continue to receive the SCHIP match rate.

The Bad News:

- The bill includes only \$35 billion in funding for SCHIP and Medicaid (\$50 billion was budgeted).
- Childless adults and parents will be phased out within 2-3 years. This directly impacts New Jersey since under NJ FamilyCare, New Jersey also provides coverage for parents of children enrolled in SCHIP.
- The bill does not include a Medicaid and (S)CHIP Payment Advisory Commission (but does include a GAO study analyzing access).

If enacted, the provisions of the bill are projected to reach approximately 3.3 million children that are currently uninsured, more than half of the eligible uninsured. In addition, the funding would ensure that the 6.6 children currently enrolled in SCHIP would continue to receive dependable health care. The reauthorization will be paid for with a 61% increase in the Federal tax on cigarettes, with proportional increases for other tobacco products.

It is now more important than ever that we continue to push our members of Congress, and reaffirm the importance of a strong SCHIP reauthorization. It is becoming clear that the fight for SCHIP is no longer solely along party lines, but between those who support providing for America's children and those who support the President's threat to veto CHIP legislation in favor of a system driven by tax deductions and private health insurance. Over the past ten years, SCHIP has provided children, who would otherwise have been uninsured, with an invaluable source of health insurance. *As we move forward, it is important that we emphasize that SCHIP is about children.*

BLACK BOX LEGISLATION

This past session AAP/NJ worked closely with Assemblyman Herb Conaway, M.D. and his staff, including Dr. Ken Ganti, and Chief of Staff Kevin DiSimone to address "Black Box" legislation that would have required written consent for any prescription written for medication that has a "Black Box Warning" associated with it.

A3566 Diegnan (D18) / **S2364** Lance (R23) / Codey (D-27) requires physicians

and other prescribers to obtain informed consent from parents or guardians of minors for medications with "black box warnings." The United States Food and Drug Administration (FDA) requires pharmaceutical companies to place a "black box warning" on a drug label if medical studies indicate that the drug carries a significant risk of serious or life-threatening adverse effects. Under the bill, a physician, advanced practice nurse, or other authorized prescriber in violation of the bill is to be subject to disciplinary action by the applicable State professional licensing board. The bill was heard in Assembly Health and Senior Services Committee but did not have enough votes to pass.

Assemblyman Conaway countered this legislation effort by Assemblyman Diegnan by introducing **A4147** Conaway (D7) which requires DHSS to make list of drugs with "black box" warnings accessible through its website; and **AR251** Conaway (D7) - Memorializes Congress and President to enact legislation to require FDA to post list of drugs with "black box" warnings on its website. Both bills were heard and reported of the Assembly Health Committee.

Assemblyman Diegnan then introduced **A4245**, which requires physicians and other prescribers to obtain informed consent from parents or guardians of minors for certain medications with "black box warning." The bill was heard in the Assembly Consumer Affairs Committee and released. AAP testified on the legislation throughout the legislative process that the correct process to address medication issues was within the processes of the scientific community and professional organizations such as the FDA and the CDC rather than via the legislative arena. Parent advocates testified that their children had been given prescriptions for Paxil but were not aware that the drug had side effects including violence and increased depression. They stated that manufacturers of the drug had not made public know side effects of such drugs. AAP continues to monitor these bills and address legislative and parental concerns.

TESTING OF PREGNANT WOMEN FOR HIV

The American Academy of Pediatrics – New Jersey Chapter supported **A4218** (McKeon) / **S2704** (Codey), which requires testing of pregnant women for HIV as part of routine prenatal care unless women refuse the testing. According to Dr. Julia

Piwoz, Infectious Disease (ID) specialist at Hackensack University Hospital, who testified in the Senate Committee, recommendations state that if in a state considered to have high prevalence, as is New Jersey, then the recommendation is to test pregnant women twice during their pregnancy. It has been estimated that perinatal transmission rates can be reduced to less than two percent with universal screening of pregnant women in combination with prophylactic administration of antiretroviral drugs, a cesarean delivery and avoidance of breast feeding. Use of "patient notification" provides women the opportunity to be tested but eliminates the obligation to provide extensive pretest counseling, which has been a barrier to testing in many settings. The Institute of Medicine recommends a national policy of universal HIV testing as a routine component of prenatal care. American College of Obstetrics and Gynecology statements on this subject will be issued in the near future. The benefit of testing twice is to pick up those who seroconvert during pregnancy and we have seen multiple failures with testing based on risk alone, which is necessary in our area. Dr. Amisha Malhatra from Robert Wood University Hospital testified in the Assembly Health and Senior Services Committee on the bill. The bill was passed by the Assembly by 74-5 and by the Senate with a vote of 37-0 to approve the bills. The American Civil Liberties Union and NOW testified in opposition to the bill on the basis that they feel the bill deprives women of authority to make medical decisions and deprives them of their privacy.

DOBI LEVIES \$9.5 MILLION

PENALTY AGAINST

AETNA HEALTH

The Department of Banking and Insurance released the following statement on the \$9.5 million dollars in fines levied against Aetna Health:

TRENTON – On Monday the Department of Banking and Insurance (DOBI) filed an administrative order levying \$9,475,000 in fines against Aetna Health Inc. for refusing to appropriately cover certain services provided by out-of-network health care providers – including emergency treatment – in violation of New Jersey rules and regulations.

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Report from the New Jersey Legislature

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In June, DOBI received numerous complaints after Aetna issued a letter to health care providers stating that the company had determined what was "fair payment" for services rendered by non-participating physicians and health care facilities and that "additional reimbursement would not be considered." This included services by non-participating providers that were required under New Jersey law, such as emergency care, services provided by non-participating providers during an admission to a network hospital, and services rendered as the result of a referral or authori-

zation by Aetna.

The letter stated that Aetna determined that 125 percent of the Medicare allowable amount was fair payment, and 75 percent for lab fees and durable medical equipment. As a result, many patients were subject to receiving bills for the amount Aetna would not pay, creating significant financial exposure. Under such circumstances, New Jersey regulations state that members of a health maintenance organization (HMO) have the right to "be free from balance billing by providers for medically necessary services..."

DOBI Commissioner Steven M. Goldman signed the order requiring Aetna to cease its limited reimbursement practice, to reprocess all claims for services rendered by non-participating providers adversely affected by Aetna's unfair practices, and make payment to those providers based on the billed amount plus 12 percent interest from the date the claim was initially paid, in addition to the monetary penalty.

Aetna has 30 days to request an administrative hearing objecting to the order. If no hearing is requested, the order will then become final.



What's at AAPNJ.ORG

Last November saw the debut of the first major revision of our chapter web site since it's inception over eight years ago. Hopefully members will have found it to be a useful means of keeping abreast of the chapter's accomplishments as well as a valuable tool to find out about program offerings and services.

This month we are happy to announce the resumption of the Jobs Board, a bulletin board for both practices and practitioners seeking one another. It can be found under the Resources section on the main page. Candidates seeking employment and practices looking for employees can fill out and submit their respective forms. They will be reviewed and if accepted posted to the board. A confirmation email will include a password which will allow the submission to be edited in the future.

Feel free to contact headquarters (hq@aapnj.org) or the webmaster (webmaster@aapnj.org) with any questions. In addition, anyone wishing to have their practice website included in the listing of New Jersey Pediatric Practices found under Websites in the Resource section may e-mail the link to either of those addresses. Please reference AAP/NJ in the subject line for all correspondence.

Mark Your Calendars!!!

These are some of the AAP/NJ Chapter meetings that are planned for 2007.
Please plan on attending and encourage your colleagues to attend as well.

For details on any of the events:
609-585-6871 or visit www.aapnj.org



October 17, 2007

CME Teleconference - Adolescent Immunizations. 12:15-1:30pm. Dr. Lawrence Frenkel. More details to follow.

October 25, 2007

Sixteenth Annual School Health Conference - Community Medicine: School Children and Your Practice. The Palace at Somerset Park, Somerset, NJ. 7:00 am to 3:00 pm.

November 14, 2007

CME Teleconference - Probiotics. 12:15-1:30 pm. More details to follow.

December 11, 2007

CME Dinner - Dr. Seth Orlow. More details to follow.

RUTGERS, THE STATE UNIVERSITY OF NEW JERSEY,
THE GRADUATE SCHOOL OF APPLIED AND PROFESSIONAL PSYCHOLOGY,
AND THE TOURETTE SYNDROME ASSOCIATION OF NEW JERSEY

are pleased to offer

An Overview of Habit Reversal for Tourette Syndrome

with Dr. Doug Woods

Wednesday, September 26, 2007, 5-7 pm
On the campus of Rutgers University

There is no charge. A complimentary buffet dinner will be provided. Registration required, seating limited—see RSVP info below.

Habit Reversal is a non-pharmacological approach to treating both motor and vocal tics.

It is one of the more promising non-drug treatments which involves helping an individual with TS become more aware of when a tic is about to occur and then training that person to replace the tic with a less bothersome physical response. Studies have shown that this type of behavior therapy can reduce tic severity by up to 30 percent and has been shown to be equally effective as some of the most successful medications currently used to treat tics.

Dr. Doug Woods received his Ph.D. in Clinical Psychology from Western Michigan University. Dr. Woods is currently on the faculty of the Clinical Psychology Ph.D. program at the University of Wisconsin-Milwaukee, where he is an Associate Professor and Director of Clinical Training. Dr. Woods, a founding member of the Tourette Syndrome Association's (TSA) Behavioral Sciences Consortium is a member of TSA's Medical Advisory Board and serves on the Scientific Advisory Board of the Trichotillomania Learning Center. He has been funded by the TSA Grants program, Trichotillomania Learning Center Grants program, and is currently funded by the NIH as part of two separate multisite research projects investigating the efficacy of behavior therapy for children and adults with Tourette Syndrome. Dr. Woods has authored or co-authored 90 papers or chapters and two books on TS and related disorders. Dr. Woods has also presented his work nationally and internationally with over 140 conference presentations and numerous invited talks. In addition to his active research program, Dr. Woods operates a clinic for children with tics and trichotillomania in the Milwaukee area. In the last 5 years, Dr. Woods has seen over 150 youth and families with these debilitating disorders.

**To reserve a space, please call Judi at 732-445-7795 ext 10
or e-mail to jabkuldi@rci.rutgers.edu by September 10, 2007**

Another continuing education presentation from:



**New Jersey Center for Tourette Syndrome
and Associated Disorders, Inc.**

50 Division Street Suite 205 Somerville NJ 08876 908 575 7350 www.njcts.org

A multi-disciplinary, cross-institutional organization, working with the Tourette Syndrome Association of New Jersey, Inc., a non-profit 501(c)(3) corporation serving the needs of individuals with TS and their families. 908 575 7350

Election Results-New Officers and Councilors

Elections – All Members Shape the Future

The AAP/NJ Chapter Executive Council and Nominating Committee elections were held from April 1 through April 30, 2007. Several Members will be serving their first terms, while others were re-elected. The Executive Council serves as a voice for all Chapter Members and encourages communication with you, the Members. Members of the Executive Council are liaison to numerous government agencies as well as community-based organizations. Through its committees, all pediatricians can make a difference.

Elected as District Councilors were:

Dr. Daniel Schwartz	District 1
Dr. Walter Rosenfeld	District 3
Dr. Patty Vitale	District 5
Dr. Jeanne Craft	At-Large
Dr. Pierre Coant, Nominating Committee	District 5

Thanks to all the leaders who have served our Executive Council well and with distinction. The following members' terms have concluded, and we greatly appreciate their guidance and wisdom over the years:

Dr. Alex Hyatt	District 1
Dr. Jeanne Craft	District 3
Dr. Joseph DelGiorno, Nominating Committee	District 5

Continuing their terms are:

Dr. Kathleen Greaney	District 1
Dr. Ellen Ganek	District 2
Dr. Noha Polack	District 2
Dr. Daniel Hermann	District 3
Dr. Michele Patran Tuck	District 4
Dr. Ernest Leva	District 4
Dr. Pierre Coant	District 5
Dr. Elaine Donoghue	At-Large
Dr. Wayne Fellmeth	At-Large
Dr. Jill Stoller	At-Large
Dr. Bipin Patel, Nominating Committee	Chairman
Dr. Jeffrey Boscamp, Nominating Committee	District 1
Dr. Howard Kornfeld, Nominating Committee	District 2
Dr. Kristin Walsh, Nominating Committee	District 3
Dr. William Wassel, Nominating Committee	District 4
Dr. Steven Kairys, Nominating Committee	At-Large

As a reminder, the AAP/NJ Chapter State Districts are comprised of these Counties:

District 1

Passaic
Bergen

District 2

Essex
Hudson
Union

District 3

Sussex
Warren
Morris
Hunterdon
Somerset

District 4

Middlesex
Mercer
Monmouth
Ocean

District 5

Burlington
Atlantic
Camden
Gloucester
Salem
Cumberland
Cape May

All AAP/NJ Chapter Members are encouraged to actively participate in Chapter activities and committees. Contact your District Councilors *TODAY!* (Phone numbers and email addresses will be available at www.aapnj.org.)

PROS (Pediatric Research in Office Settings) Study Open

PROS (Pediatric Research in Office Settings), a nationwide group of AAP practices is looking for "a few good practices", interested in conducting practice based research.

The current study in the field is Secondary Sexual Characteristics in Boys (SSCIB), which is trying to answer the question: when do boys start puberty and

are there differences based on race, body mass index?

Other studies underway or soon to be started are looking at:

- Adolescent Smoking Cessation
- Parental Smoking Cessation Counseling
- Obesity Prevention

- Telephone Based Parent Training
- Translating Violence Prevention Evidence into Practice

If you are interested and want to learn more about PROS, check AAP website www.aap.org/pros or feel free to call Harris Lilienfeld, MD, FAAP Chapter Coordinator for New Jersey at 609-896-4141 or email lilienfeld@aol.com



SAVE THE DATE

PEDIATRIC ASTHMA SEMINAR

THEME: The Community Practitioner as an Asthma Specialist

DATE/TIME : October 2, 2007 from 8 a.m. to 1 p.m. (with breakfast and lunch)

PLACE: Lance Auditorium, K. Hovnanian Children's Hospital at
Jersey Shore University Medical Center
1945 Rte 33, Neptune, NJ 07753

EXPERT FACULTY: Drs. Julian Allen, Leroy Graham Jr., and David P. Skoner

TOPICS: Controversies in Asthma Management, Addressing the Asthma Crisis, National Guidelines and Community-Based Strategies, and Current Management of Asthma, Variations in Response and Outcomes

CME credits, category 1-- 3 hours

Registration fee: \$ 25

TARGET AUDIENCE: Pediatricians, Family Practice Physicians, Residents, Nurses, Nurse Practitioners, Allied Health Professionals who care for children with asthma

Contact : sscales@meridianhealth.com for details or further questions
Telephone: 732-776-4267

This Program is sponsored by Jersey Shore University Medical Center.

The JERSEY SHORE UNIVERSITY MEDICAL CENTER DIVISION OF MERIDIAN HOSPITALS CORPORATION is accredited by the Medical Society of New Jersey as a provider of continuing medical education and as such is bound by the MSNJ/ACCME Standards for Commercial Support and the MSNJ Essentials and Standards.

JERSEY SHORE UNIVERSITY MEDICAL CENTER designates this CME activity for a maximum of 3 hours *AMA PRA category 1 credit*.™ Physicians should only claim credit commensurate with the extent of their participation in the activity.

DISCLOSURE STATEMENT

JERSEY SHORE UNIVERSITY MEDICAL CENTER, in approving courses for Category I Credit, adheres to the ACCME, "Guidelines for Commercial Support" Jersey Shore University Medical Center is responsible for every aspect of the program it certifies, and faculty participants are expected to disclose any commercial relationship that might be perceived as a real or apparent conflict of interest.

Annual School Health Conference

Wayne Yankus, MD, FAAP, Chair, School Health Committee



Patients who travel and present to your office with medication requests—what to recommend? Schools that drug test your patients and ask for your interpretation or intervention. How do you handle that in a world of HIPAA? Behavior crisis that happen at school and you are asked to recommend therapy.

These are some of the topics that are covered in a lively debate at the presentations and workshops at this fall's Community

Medicine and School Health Conference on October 25 at The Palace at Somerset, Somerset, NJ.

Come and join your colleagues in this CME event from 8 AM to 3 PM and share your expertise and learn how you might improve your practice.

To obtain a registration form go to AAP/NJ's website aapnj.org or call 609-585-6871.

AAP/NJ's Annual Meeting

Below are some photos from the recent AAP/NJ's Annual Meeting which was held on June 13, 2007 at the Hyatt Regency, New Brunswick.



Dr. Stephen Rice, MD, PhD, MPH, FAAP during his presentation on Concussion Management 2007-What Today's Pediatrician Needs to Know.



Dr. Wayne Yankus, MD, FAAP was honored for his generosity of spirit, time and talent.



Drs. Janice Pronnicki, MD, FAAP and Elaine Donoghue, MD, FAAP. Dr. Donoghue was recognized as outgoing CATCH representative.

Reducing Missed Opportunities to Immunize Adolescents

Providing quality health-care involves consideration of current and long-term risks and benefits. In the case of immunizing adolescents against vaccine-preventable diseases, the benefits are significant. Adolescents are often at increased risk for infection and disease complications, the consequences of which may not emerge until adulthood.

The best defense against vaccine-preventable diseases remains *immunization*, including annual influenza vaccination and a booster dose of tetanus/diphtheria/acellular pertussis (Tdap) vaccine that provides protection against pertussis (*whooping cough*), as well as tetanus and diphtheria.

Adolescents may not receive all recommended immunizations, in part, due to missed opportunities during routine visits to their doctors. Claims data from the United States (US) in 2003 shows that approximately 26.6 million adolescents (11-18 years of age) visited their doctors for preventive and acute/chronic care—yet only about 6% of their visits were related to immunization.¹ Furthermore, only 8% of adolescent visits were coded as preventive.¹ This data clearly indicates a significant number of missed opportunities for adolescent immunization. Health-care providers can take better advantage of preventable and acute/chronic care office visits to ensure that adolescents are immunized.

Immunizing adolescents reduces the spread of diseases

The benefits of immunizing adolescents against disease are far-reaching—influenza and Tdap immunizations are cases in point. A clinical study in Japan showed that immunizing schoolchildren 7-15 years of age against influenza led to a drop in influenza and pneumonia-related deaths in all age groups; the same study also showed that, when an immunization program for schoolchildren was discontinued, the number of influenza-related deaths among the elderly increased.² Due to this *herd immunity*, annual adolescent immunization can significantly prevent the spread of influenza to the vulnerable elderly.

Adolescents are also a pathway for spreading pertussis. During adolescence, immunity to pertussis may begin to wear off.³ Since adolescents may have waning immunity or get milder cases of pertussis, they may unknowingly transmit the disease to infants.⁴ Unfortunately, infants suffer the most severe and deadly complications from pertussis.⁴ A single Tdap booster vaccine protects adolescents from pertussis and helps prevent the disease from spreading to infants.

In addition to preventing the spread of infection, immunization helps protect adolescents against the lifelong risks of vaccine-preventable diseases.

Risks inherent in adolescence

A number of clinical studies profile the significant disease risks faced by adolescents in the US:

- From 1992-1999 in Maryland, meningococcal disease mortality rates were highest among adolescents and young adults 15-24 years of age⁶
- In 2004, approximately 38% of reported pertussis cases were among persons 10-19 years of age⁶
- Infection rates during a typical influenza season are usually highest (25%-43%) among children⁷
- Up to 10% of the young adults who contract hepatitis B virus (HBV) become lifetime carriers; currently as many as 1.25 million people in the US are chronic HBV carriers⁸

These disease risks among adolescents directly impact the health of other age groups, such as infants and the elderly, because adolescents are a source for transmission of disease-causing organisms. Children in the US are often a pathway for transmitting influenza, especially to persons in the same household.⁷ Furthermore, results from a Centers for Disease Control and Prevention (CDC) study indicate that adolescents may be the source of pertussis in approximately 20% of US reported infant cases where a known or suspected source was identified.³

Due to these significant disease risk factors and the potential for spreading infection, adolescent immunization offers important protection against vaccine-preventable disease.

Potential benefits of adolescent immunization on disease reduction

Results from several studies support the concept that increased adolescent vaccination coverage can improve health outcomes, including increased disease prevention and reductions in associated morbidity and mortality.

The following table cites studies that estimate potential positive health-status outcomes based on increasing adolescent vaccination coverage.

Estimated Impact of Increased Adolescent Immunization Rates on Outcomes

Estimated Level of Immunization Coverage*	Reductions in Disease and Complications
<i>Influenza immunization (Japanese study):</i> 50%-85% of children 3-18 years of age	‡ 37,000-49,000 deaths annually from all causes in all age groups ²⁰
<i>Meningococcal disease immunization (United Kingdom study):</i> 85% persons 0-17 years of age	88% drop in incidence of serogroup C disease in persons 10-17 years of age within 18 months of start of vaccine program ⁴⁰
<i>Human papillomavirus (HPV) immunization:</i> Vaccinating all females 12 years of age	Estimate of lifetime cases averted: ⁴¹ ‡ >224,255 cases of HPV infection ‡ 3316 cases of cervical cancer ‡ 1340 cervical cancer deaths
<i>Hepatitis B (HBV) immunization:</i> Each 1-year age group of vaccinated adolescents	Estimated projections: ⁴¹ ‡ 160,000 HBV infections ‡ 10,000 chronic infections ‡ 1400 hepatitis B-related deaths later in life

*Study results

Raising awareness about the benefits of adolescent immunization

To improve adolescent immunization rates, health-care professionals need to raise awareness about the lifetime benefits of immunizing against vaccine-preventable diseases. For example, some diseases that can be acquired in adolescence, such as HBV and HPV, may be asymptomatic, and the consequences of the disease may not appear until later on in adulthood.

By encouraging adolescent immunizations, health-care professionals help to:

- Protect adolescents during a period of increased risk
- Prevent lifelong complications for adolescents in the future
- Increase overall immunity in all age groups

Parents also need to be educated about the importance of maintaining current vaccinations for their children and themselves; and viewing routine office visits as an opportunity to catch up on vaccinations.

When it comes to immunizations, consumers value the recommendations of their personal physicians and medical staffs. A proactive approach by health-care professionals can be instrumental in educating families about the disease risks of adolescents and the lifelong benefits of recommended immunizations.

Improving adolescent immunization coverage will reduce the risk of disease now and into adulthood—and health-care professionals are best positioned to impact this important goal.

Tdap recommendations for adolescents

The CDC recommends Tdap vaccination for all adolescents:¹²

- A single dose of **Tdap** for adolescents 11-12 years of age who have not received a tetanus/diphtheria (Td) booster dose¹²
- A single dose of **Tdap** for adolescents 13-18 years of age who missed the Td/Tdap booster dose at 11-12 years of age¹³
- A single dose of **Tdap** for adolescents who previously received a Td booster. A 5-year interval after the last Td vaccine is usually encouraged, but shorter intervals can be used¹²

Influenza immunization recommendations for adolescents

The CDC recommends vaccination with inactivated influenza vaccine for adolescents, including¹⁴:

- Those with chronic medical conditions, such as:
 - Disorders of the pulmonary or cardiovascular systems, including asthma
 - Chronic metabolic diseases, including diabetes mellitus
 - Renal dysfunction
 - Hemoglobinopathies
 - Immunosuppression, including that caused by HIV or medications
 - Any condition that can compromise respiratory function, including cognitive dysfunction, spinal cord injuries, seizure disorders and other neuromuscular disorders
- Those through 18 years of age who are receiving long-term aspirin therapy and are thus at risk for experiencing Reye syndrome after influenza infection
- Those who live in households with children 0-59 months of age
- Those who will be pregnant during the influenza season

References: 1. Clegg DM, et al. Food safety physicians' office. Surveillance Data Unit. March 2014, on file with coauthor postscript file: NKT9103.

2. Reichert TA, Suggs MA, Edison DS, Gleason RW, Simonson L, Tachiro M. The Japanese experience with vaccinating schoolchildren against influenza. *N Engl J Med*. 2001;344:669-669. 3. Bisgaard HM, Pascual FB, Christenson VR, et al. Infant pertussis: who was the source? *Pediatr Infect Dis J*. 2004;43:925-929. 4. Centers for Disease Control and Prevention (CDC). Pertussis. In: *Allison W, Hamborsky J, McIntyre L, Wolfe C, eds. Epidemiology and Prevention of Vaccine-Preventable Diseases: The Pink Book*. 9th ed. Washington, DC: Public Health Foundation; 2006:79-93.

5. Harrison LH, Pass MA, Nendelknecht AJ, et al. Invasive meningococcal disease in adolescents and young adults. *JAMA*. 2001;286:694-699. 6. CDC. Pertussis Surveillance Report-8/10/2005. Issues 1-52, 2004. (Final data). Unpublished data. 7. Weycker D, Edelstein J, Hahnlon ME, et al. Population-wide benefits of routine vaccination of children against influenza. *Vaccine*. 2005;23:1294-1293. 8. American Liver Foundation. Hepatitis B and chest. Available at: <http://www.liverfoundation.org/life/life1062>. Accessed August 10, 2006. 9. Miller E, Salisbury D, Ramsay M. Planning, registration, and implementation of an immunisation campaign against meningococcal serogroup C disease in the UK: a success story. *Vaccine*. 2002;20:S56-S67.

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Are you *protecting* them against meningococcal disease?



Improved inventory and supply of meningococcal vaccine has prompted the Centers for Disease Control and Prevention (CDC) to reinstate the full Advisory Committee on Immunization Practices' (ACIP) recommendation for meningococcal vaccination.¹



Health-care professionals can once again administer meningococcal vaccine to **all** of the recommended immunization cohorts:¹

- **Young adolescents**
(11–12 years of age)

And if they have not been previously vaccinated with MCV4 vaccine

- **Teens entering high school**
(≈15 years of age)

- **College freshmen living in dormitories**



Now that adequate supplies are available the CDC also encourages health-care professionals to continue to **call back those adolescent patients for which meningococcal vaccination was deferred.**¹



Keep supply of meningococcal vaccine on hand and take advantage of every opportunity to immunize year round.

Brought to you as a public health service by Sanofi Pasteur Inc.

Reference: 1. Centers for Disease Control and Prevention. Notice to readers: improved supply of meningococcal conjugate vaccine, recommendation to resume vaccination of children aged 11–12 Years. *MMWR*. 2006;55(43):1177.

New Jersey Takes Note: “Reach Out and Read” Works

Kim Byam

“Books are not just glorified lollipops. They are so much more than that,” says Katarzyna Madejczyk, M.D., a pediatrician at the Jersey Shore University Medical Center. Dr. Madejczyk has been very active in “Reach Out and Read” (ROR) in New Jersey for several years, and she has given away thousands of books to her young patients. She has seen the difference the program has made for many young children and their families.

“Reach Out and Read” is a nationwide program that makes literacy promotion a standard part of pediatric care, so that children grow up with books and a love of reading. There are forty-nine ROR sites in hospitals, health centers and pediatric practices throughout the state.

In Jersey Shore University Medical Center’s exam rooms, like many other exam rooms throughout the state, doctors trained in ROR strategies of early literacy talk to parents about the importance of reading aloud to young children and offer age-appropriate tips and encouragement. The program is for children ages six months to five years, with a special focus on children growing up in poverty.

Dr. Madejczyk stresses the fact that the program is easy to implement and takes little of the provider’s visit time. “Giving a book and anticipatory guidance takes two minutes. It’s so easy, but with such far-reaching effects on a child’s future,” she says.

Last year, New Jersey doctors gave away more than 75,000 books to almost 49,000 of the state’s lowest-income children. Doctors participating in ROR distribute carefully selected, new, developmentally and culturally appropriate books: starting with board books for babies and moving on to more complex picture books for preschoolers. Bilingual books are available in 12 languages. Each child who participates in the program starts kindergarten with a home library of up to ten books and

a parent who has heard at every well-child visit the importance of books and reading.

Research Shows: ROR Works

Published research shows that ROR works. Low-income children exposed to the program show improved language development, a critical component of school readiness. Early language skills develop from exposure to the words of parents and other adults, and reading aloud allows for more exposure to more words.

Compared to families that have not participated in the program, parents who receive the ROR intervention are significantly more likely to read to their children and have more children’s books in their home. Most important, children served by the ROR program show an increase of 4-8 points on vocabulary tests. For a two-year old child, this increase represents an approximate six-month gain, developmentally speaking, preventing the “falling behind” observed and measured in low-income children.

Carmen Mallamaci, M.D., a provider at North Hudson Community Action Corporation Health Center in West New York has seen this first-hand. “By providing books and the message that reading aloud is critical for language development, we provide parents with real tools they can use to help their children succeed in school,” she says. “Even if a parent struggles with reading, by merely looking at pictures with their child, labeling familiar objects or using the book as a starting point to fashion their own story, they can initiate their child into the joy of reading.”

Giving a young child a book in the pediatrician’s office is not only helping with cognitive development, but is also an important tool doctors can use when evaluating their patients during a routine well-visit. By providing a new book at the beginning of a well-visit, providers find they can better engage and calm the child, provide

strong and helpful positive messages to the parent and build connections with the family. Using the book opens up the opportunity to talk about other matters, healthy routines, sleep issues, and school readiness.

“The ROR model helps families, and really the entire community, encourage early literacy skills so children are prepared for school and success in reading,” says Dr. Madejczyk. She adds: “The ROR program should be present in every area of our state, especially in all areas where low-income children live.”

A New Partner Donates Major Funds for Expansion

New Jersey’s “Reach Out and Read” program recently launched a partnership with the Healthcare Institute of New Jersey (HINJ) that will help with its goals of expansion throughout the state. HINJ and its member companies have made a three-year, \$100,000 per year, commitment to ROR in New Jersey. One of the main partnership goals is to expand the program to underserved areas.

Bob Franks, the President of HINJ, said, “What really caught our attention is that the program actually works! In promoting early childhood literacy, we open a world of opportunity for our children, and that is why we have decided, as an industry, to partner with ‘Reach Out and Read.’”

How To Become a ROR Site

The grant from HINJ has created momentum for expansion of ROR in New Jersey. ROR is currently seeking providers throughout the state who want to offer the program.

If you are interested in learning more about ROR and starting the program at your site, please contact Kim Byam, Director of Reach Out and Read – New Jersey (973/660-0613 or kim.byam@yahoo.com). For more information about the ROR model go to www.reachoutandread.org.

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Infectious Diseases Corner

Margaret (Meg) Fisher, MD, FAAP

Vaccines continue to be the latest news in the world of infectious diseases: both new and new recommendations. With new opportunities come new barriers. We can now protect our children from 16 vaccine preventable diseases; in New Jersey we are trying to protect our pediatricians as well. Vaccine payment has failed miserably to meet the increasing costs of running a practice. Pediatricians are left wondering what to do and how to survive and offer the best care to their patients. At the national level, the Academy is working with the Centers for Disease Control and Prevention, the vaccine manufacturers and the health care insurance industry to address what has become a crisis for pediatricians. At the state level, our practice committee and government affairs committees are hard at work as well.

There is a new emphasis on the preteen visit and vaccination at this visit. The recommended vaccines for the 11 to 12 year old include Tdap, meningococcal conjugate vaccine, human papillomavirus vaccine for girls, and a second dose of varicella vaccine for all who did not have documented varicella (natural or breakthrough cases). If the visit is during the fall, consider influenza vaccine as well. Do we really need all these vaccines? I vote a major YES! Pertussis is endemic in New Jersey; I have treated half a dozen infants over the past 2 years and it is not a pleasant disease. The adolescent and adult booster should change the epidemiology and prevent infection in the very youngest. Remember that it takes several doses of DTaP before an infant is protected; the new idea is to cocoon the baby by ensuring that all household contacts are immunized! This means we should remind all new parents that Tdap is meant for them! Of course, we should all have received our booster already. If you haven't, there is no time like the present. Why not make it an office affair? All of your staff should be protected against pertussis and of course against influenza; fall is a fine time to accomplish this!

Although meningococcemia is most common in children under 2, the incidence begins to rise again by age 15 and the serotypes involved are those in the conjugate vaccine. There is now enough vaccine available to immunize all adolescents; so check your records and be sure to recall those who need it. Human papillomavirus vaccines are currently recommended only for girls and young women; the antibody response to the vaccine is higher in 16 year olds than in 26 year olds and highest in the 9 year age group. The vaccine is effective in preventing infection but does nothing for those who are already infected. Thus our job is to protect preteens before they become infected! The efficacy data for boys is being acquired and should be available soon so stay tuned for changes in the recommendations. Sure, boys don't get cervical cancer but they do get genital warts and they are very important in transmis-

sion of the virus. What about varicella? The vaccine is highly effective at preventing death from varicella but it has not been effective in fully preventing breakthrough infections. These children can transmit wild virus to unprotected children: those whose parents chose not to immunize them and of course those who are immunosuppressed and can't receive live virus vaccines. Those at highest risk for complications of varicella are teens and adults as well as the immunosuppressed individuals of all ages. The second dose of varicella vaccine is designed to prevent breakthrough disease. The dose will be given routinely at age 4 but there is a large group of children in your practices who have received a single shot; these children need the second dose and you can give it at any visit. There is even a new vaccine for older adults, Zostavax, which is licensed for use in adults over the age of 60 years. It boosts a person's immunity and prevents or at least decreases the incidence of zoster. For anyone who has watched a colleague or parent suffer with zoster, you will appreciate that this vaccine is great news for baby boomers!

Rotavirus vaccine continues to be safe; the post-licensure studies again confirm that there is no link with intussusception. This is a live oral vaccine but transmission is uncommon and there is no evidence that the vaccine causes disease in household contacts. It should be given to young infants in households with compromised adults since otherwise, these infants would be likely to introduce the wild virus into the household. The major contraindication to rotavirus vaccine is age; the first dose must be given before 13 weeks. The reason is to avoid giving that dose to infants at the time that background intussusceptions becomes more common (beyond 3 months). When we hit the season, remember that this vaccine causes a positive rotazyme test.

Finally, what is new with influenza? The recommendation remains to immunize all children from age 6 months to 5 years and all of their household contacts; that alone should account for most of your practice. Add to it just about any child with an underlying chronic illness and all their contacts and anyone who wants to decrease their risk of influenza. So the question becomes not should I immunize this child but is there any reason not to immunize this child. Reasons not to would be anaphylaxis to eggs or age under 6 months. The live attenuated, cold adapted vaccine has been approved in a refrigerator stable form. The company hoped for a change in the age indication but as of August 2007, the vaccine is approved only for healthy children and adults between the ages of 5 and 50 years. Stay tuned since this could change. The safety and efficacy studies suggest the vaccine can be used in younger children and in those with asthma but it is not yet licensed for this age or for anyone with any underlying illness.





Timeless Seniority

Avrum L. Katcher, MD, FAAP
Chairperson, Section for Senior Members

First, my understanding, from the august, eminent linguistically unchallenged New York Times. In response to an op-ed column by Professor S. Scott Whitlow, Adam Redfield emphasized that the very term, "chairperson", is poor English and not to be used except by those who seek ignominy. I've used it for many years, since I felt that chairman is a sexist term, like motorman. As a young attending, working with second year medical students (late 1960s or early 1970s) to teach history taking and physical diagnosis, one of the groups I sought to help was composed of four women. At some point, seeking to move them along, I said, "Come on guys, let's see what we can learn from this patient." The air became a bit chilly, but we went on our way.

A few days later the chairman (he was a male person) of community medicine, who happened to be in charge of the teaching program called me. The four ladies had filed a complaint. By calling them "guys" I had insulted their femininity. I barely suppressed a laugh. All of our children (three girls and a boy) used the term "guy" indiscriminately to identify a friend, associate or classmate. But I did not forget, and have been on the lookout since. For example, each morning about 11:30 our roadside mailbox receives USPS material from a mail carrier. Our trash is picked up by a trash collector. And, by golly, I am, and shall remain until the end of my term, a chairperson. So fie on you, New York Times!

You will be hearing more later this year and next year about what we hope will be a

new venture of the Section for Senior Members. That will be a more formal structure and set of objectives for our group. My interest goes back to 1993, when we were a provisional section whose survival was a bit uncertain. At that time we did a survey of members, noting that of 390 responders, 70% described their health as unimpaired. Of those age 70 or over, that proportion dropped to 54%. Just over 23% said that they were less satisfied with life than ten years previously. Gender, state of health and occupational status showed a small association with satisfaction.

Whatever the reason, it was felt that AAP needed to know more about this drop-off in satisfaction. Does it really exist? If so, why, and what could or should be done to ameliorate the situation for this group? It was clear in 1993 that the health care system in its relationship to the entire economy, would be a zero or negative sum system for the future. That prediction has been found true. We felt issues of efficiency, effectiveness and economy would be ever more prominent. We said:

"One of the most expensive of all resources used for child health is the pediatrician. Each one costs the economy many millions of dollars over a lifetime. A great deal of research is devoted to the effectiveness and efficiency of a variety of medical treatments, drugs, procedures, appliances. Some research is done relating to how the pediatrician utilizes herself or himself. Very little is done on the pediatrician to answer questions about the relationship between perceived life satisfaction, or stress, and the quality of that individual's professional perform-

ance, or on the trajectory of that person's career, how long that individual remains in the medical profession, and why."

"Just as in child health care, a pediatric career can be viewed from a developmental perspective. There are characteristic milestones, times for important decisions, expected attainments. Progress may be enhanced by factors which promote resiliency and impaired by factors promoting vulnerability. Little is known of these factors."

I would contend that the above description is valid today. I would further contend that the Section for Senior Members should take the lead to work with the AAP to see what might be done for the individual pediatrician. It has been quite some time since AAP recognized the importance of working not only for the welfare of children, but also for the effectiveness, efficiency and self-utilization of pediatricians. That is, the satisfactions taken from work, and the blending of professional and personal lives. We have begun some of this already. Look at our web site, so ably created and maintained by Jerry Aronson. Here you'll find a bonanza of information about living well, pre-retirement issues, health and fitness and other links to enable you to maintain yourself in the best possible condition, both while in practice and subsequently.

We have made other suggestions, and are now entering into a stage of planning, in consultation with Ken Slaw, Director of the Department of Membership, and Jackie Burke, our section manager. Keep alert! We'll need to work together.



AAP National Encourages Voter Participation

This year, the AAP election will be held throughout the month of September. The electronic ballot opens on August 30, 2007. Between August 30-31, voting members will receive a broadcast e-mail from the AAP election vendor with instructions on how to access the ballot. The only election credentials you will need for the electronic ballot are your last name and AAP ID number. The link to the election ballot, which will not be activated until August 30, is <https://www.directvote.net/aap2007/>. For those members who prefer to use a paper ballot, paper ballots will also be sent to all voting members.

Information on the national and district candidates can be found on the AAP Member Center and in the April through August issues of AAP News.

Please exercise your membership privilege and vote for the candidate(s) of your choice in the 2007 National AAP Election. Please remember, voting members include the following: Full Fellows, Specialty Fellows, Dual AAP/CPS Fellows, Dual ACP-ASIM/AAP Fellows, Life Fellows, Emeritus Fellows, and Retired Fellows.

For any questions regarding the election, please contact Jan Page, Director, AAP Board of Directors Administration, 1-800-433-9016, ext. 7502 or jpage@aap.org.

New Pediatric Case Definition Helps Pediatricians Diagnose Chronic Fatigue Syndrome (ME/CFS)

Rosemary Underhill, MB, BS (UK), Kenneth J. Friedman, PhD

There is a new, pediatric case definition for Chronic Fatigue Syndrome (CFS) developed by an international working group of the International Association for Chronic Fatigue Syndrome (IACFS/ME). The definition appears in print in the *Journal of Chronic Fatigue Syndrome* (Jason et al., 2006) and is available on the IACFS/ME website (www.iacfs.net).

Chronic Fatigue Syndrome (CFS) is an illness that affects more adult women than men, but also occurs in children and adolescents. Diagnosing CFS is difficult because there is no clinical test indicating a positive diagnosis. The diagnosis of CFS in adults depends upon the patient meeting the criteria of the generally accepted, international case definition (Fukuda et al. 1994). Diagnosing children using the adult case definition has been very problematic. The Fukuda case definition does not capture all adult patients with CFS, and captures even fewer children and adolescents with CFS. Hence the development of the new pediatric case definition containing diagnostic criteria specific for children and adolescents is a big step forward.

Pediatricians reading about CFS need to be aware that CFS is the name used in the United States, whereas, Myalgic Encephalomyelitis (ME) is the name used in Europe and elsewhere. To be inclusive, the acronym ME/CFS is gaining popularity worldwide and is also used in the new pediatric case definition (Carruthers et al. 2003, and Jason et al. 2006).

For a child or adolescent to be diagnosed as having ME/CFS under the new criteria the following conditions need to be present:

- Unexplained, persistent, or relapsing fatigue that has lasted for at least three months. The fatigue is not the result of ongoing exertion, nor is it relieved by rest. The fatigue must result in a substantial reduction in previous activities
- The concurrent persistence or recurrence of symptoms, from each of the following five groups, for at least three months:
 1. Post-exertional malaise, fatigue, or worsening of other symptoms,

with loss of mental and/or physical stamina, and delayed recovery of more than 24 hours

2. Un-refreshing sleep, disturbance of sleep quantity or rhythm, daytime hypersomnia, nighttime insomnia and/or day/night reversal
3. Widespread or migratory pain, which can be located in the muscles, the joints (without signs of inflammation), the abdomen, the chest, the eyes (or sensitivity to light), or an increase in severity of headaches, or nausea or vomiting
4. Two or more neuro-cognitive manifestations, including impaired short term memory, difficulty in concentration or focusing, difficulty finding words or numbers, absent mindedness, slowness of thought, difficulty understanding information and expressing thoughts, educational difficulties
5. At least one symptom from two of the following three subcategories:
 - a. Autonomic manifestations, including neurally mediated hypotension, postural hypotension, postural orthostatic tachycardia, palpitations, dizziness, shortness of breath, disturbed balance
 - b. Neuro-endocrine manifestations, including feeling of feverishness, cold extremities, low body temperature, sweating, intolerance to heat or cold, change of appetite or weight. Symptoms worsen with stress
 - c. Immune manifestations, including recurrent flu-like symptoms, sore throats, fevers and sweats, tender lymph nodes, new sensitivities to food, medicines, odors, or chemicals.

ME/CFS is a diagnosis of exclusion. Many illnesses with symptoms that mimic ME/CFS symptoms preclude the diagnosis of ME/CFS: untreated hypothyroidism, sleep apnea, narcolepsy, malignancies, leukemia, active hepatitis, multiple sclerosis, juvenile rheumatoid arthritis, lupus erythematosus, HIV/AIDS, severe obesity, untreated celiac disease, Lyme disease, mononucleosis, juvenile fibromyalgia, childhood schizophrenia or psychotic disorder, bipo-

lar disorder, active alcohol abuse, active eating disorder, major depressive disorder.

Other medical and psychiatric illnesses are not necessarily exclusionary: school phobia, separation anxiety, anxiety disorders, somatoform disorders, depressive disorders, fibromyalgia, multiple chemical sensitivities, any other medical condition that has been adequately treated, before or after the onset of the ME/CFS symptoms, any isolated unexplained physical abnormality or laboratory test which is insufficient to explain the presence of an exclusionary condition.

In summary, the case definition diagnoses ME/CFS primarily on the basis of pathological fatigue, the pattern of other symptoms, and the exclusion of other fatiguing illnesses by medical history, physical examination, and appropriate tests.

It is important to make the diagnosis as early as possible. While routine testing may yield normal results, specialized testing may show various abnormalities in immune, nervous and/or cardiovascular systems. Changes in cellular energy production are detectable in some patients. Adequate rest and other supportive treatment may lessen the impact of this illness. Dramatic improvement is more likely to occur in the first four years when treatment is provided. Recovery rates of up to 40% have been reported.

Not covered in the case definition but information helpful for diagnosing pediatric ME/CFS is knowing that adolescents 12 to 17 years of age are more likely to develop ME/CFS than younger children. Be aware that children as young as 4 years of age have been diagnosed with ME/CFS. In adolescents, the onset usually starts suddenly with a fever and flu-like symptoms. Diagnosis at this point may be difficult because although the symptoms are severe, the routine blood tests are normal. Moreover, the patient must be ill for three months before a diagnosis of ME/CFS can be officially made.

A gradual onset of ME/CFS occurs less frequently and is more common in younger children. In younger children, the onset may take months or several years.

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New Pediatric Case Definition

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Diagnosing ME/CFS in younger children is further complicated by the inability of younger children to appreciate that their fatigue and other symptoms are abnormal. In such cases, the diagnosis of ME/CFS may be made retrospectively when the child is older. Children and adolescents with ME/CFS often look well. A lack of obvious external physical signs of illness may mean that the first sign of illness will be a marked limitation in either physical or mental activity, which is usually first noticed by a parent or teacher. The external, well appearance of a ME/CFS child may lead to the accusation of school avoidance behavior (school phobia) or the citing of a parent for Munchausen's syndrome by proxy.

ME/CFS usually occurs as sporadic cases of the illness. Interestingly, for 20% of patients, more than one family member has the illness suggesting either an environmental or genetic link. Clusters of cases, or

outbreaks of the illness have been found worldwide. In many of these outbreaks the illness has been prominent in school-age children. The prevalence of ME/CFS in children and adolescents is uncertain. Different prevalence studies have used different criteria to diagnose ME/CFS and some have not distinguished children with chronic fatigue symptoms from children with possible ME/CFS.

The severity of ME/CFS varies. Some children are severely disabled and bedridden, while others can go to school and a few are capable of playing sports. Most children are between these two extremes. The pattern and the severity of symptoms experienced by a child may change markedly from day to day or during the day. It is important to listen to what the child has to say about the severity of his/her symptoms. Remissions and relapses are common. Relapses may be caused by over-exertion or by other infectious illnesses.

Over time, slow improvement is likely. Children whose health improves to near pre-illness levels are likely to find that they need more rest than their contemporaries.

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Diagnosing Pediatric/Adolescent Chronic Fatigue Syndrome

For a child or adolescent to be diagnosed with Chronic Fatigue Syndrome (ME/CFS) using the new Pediatric case definition the following symptoms need to be present:

- Pathological fatigue and at least seven other symptoms (see below)
- The fatigue and the symptoms are unexplained and persist, or are relapsing for at least three months. They result in a substantial reduction in previous activities
- Other fatiguing illnesses must be excluded by history of the illness, by physical examination or by medical tests.

Symptoms:	Details of symptoms:
Pathological fatigue	The fatigue is not the result of ongoing exertion. It is not relieved by rest.
Post-exertional malaise	Mild or moderate exertion is followed by malaise, fatigue, or worsening of other symptoms, with loss of mental and/or physical stamina, and delayed recovery of more than 24 hours
Sleep problems	Sleep is un-refreshing, with a disturbance of quantity or rhythm, including daytime hypersomnia, night-time insomnia and/or, day/night reversal
Pain, (at least one symptom)	Pain can be widespread or migratory. It can be located in the muscles, the joints (without signs of inflammation), the chest, the abdomen (or nausea or vomiting), the eyes (or a sensitivity to light), or a new type, or an increase in severity of headaches
Two or more neuro-cognitive manifestations	These include impaired short term memory, difficulty in concentration or focusing, difficulty finding words or numbers, absent mindedness, slowness of thought, difficulty understanding information and expressing thoughts, educational difficulties
At least one symptom from two out of these three subcategories	<ol style="list-style-type: none"> 1. Autonomic manifestations: including neurally mediated hypotension (NMH), postural hypotension, postural orthostatic tachycardia (POTS), palpitations, dizziness, shortness of breath, disturbed balance 2. Neuro-endocrine manifestations: including feeling of feverishness, cold extremities, low body temperature, sweating, intolerance to heat or cold, change of appetite or weight. Symptoms worsen with stress 3. Immune manifestations: including recurrent flu-like symptoms, sore throats, fevers and sweats, tender lymph nodes, new sensitivities to food, medicines, odors, or chemicals.

CATCH Activities Encouraged

Dear AAP/NJ Chapter:

I am happy to introduce myself as the new American Academy of Pediatrics Chapter CATCH (Community Access to Child Health) Facilitator for New Jersey.

I have been a general pediatric faculty member in the Division of General Pediatrics at Jersey Shore University Medical Center for the past 3 years. I am also a Clinical Assistant Professor of Pediatrics at UMDNJ, Robert Wood Johnson Medical School. During this time, I have had experience with the CATCH grant process by successfully sponsoring 2 CATCH Resident grants focusing on pediatric obesity.

I would like to promote CATCH activities by encouraging pediatricians and pediatric residents to develop their own community-based programs. I look forward to assuming this new responsibility with Dr. Elaine Donoghue mentoring me during this transition. As the newly appointed CATCH facilitator, I have already received 3 new CATCH applications to review and I look forward to becoming familiar and promoting further CATCH pediatricians and activities in our Chapter.

I am excited to take on this new position and look forward to working with members in our community to address issues regarding quality health care for children.

Sincerely,

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NJ Starting Agency to Coordinate Battle Against Obesity

Linda A. Johnson, Associated Press Writer

TRENTON, N.J. (AP) -- New Jersey's health department is escalating the battle against the bulge by starting a new Office of Nutrition and Fitness to better coordinate programs aimed at preventing obesity.

The agency is particularly needed in New Jersey - possibly the first state to create such a government body.

The Garden State has the highest percentage of overweight and obese children under age 5, at 17.7 percent, according to a 2004 survey by the U.S. Centers for Dis-

ease Control and Prevention. New Jersey also has many black and Latino youth, who are more likely to be overweight than white kids.

Dr. Fred M. Jacobs, commissioner of the state Department of Health and Senior Services, said young people are a crucial target for the new agency because it's easier to instill good diet and exercise habits to prevent obesity in young people than it is to reverse weight problems in adults; adults almost always gain back any weight they lose - and then some.

Jacobs says he wants to tackle the obesity problem through education, support groups and encouraging physical activity, rather than by banning particular foods. One goal is to "de-normalize" the massive portions served in restaurants.

"I want to do that without creating a further stigma on individual people," Jacobs said. "It's bad enough when you're fat that people think less of you. I don't want the government piling on."

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Battle Against Obesity

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He is mulling the idea of having schools notify parents, via report cards, about children with weight problems.

Morton Downey, spokesman for The Obesity Society, which represents doctors, researchers and others in the field, said he knows of no other state with a dedicated agency fighting obesity, although federal grants in recent years have helped numerous states develop plans to fight obesity.

He called New Jersey's initiative a very encouraging step that could become a national model.

"There's not really been an institutional base for people with ideas to go to gain support for their ideas" and funding for new Programs, Downey said.

Obesity has become the country's No. 2 cause of preventable death, after smoking. Excess weight raises risk of heart disease and stroke, type 2 diabetes, high cholesterol, asthma, depression, arthritis and several types of cancer.

In New Jersey, almost 23 percent of residents are considered obese and another 37 percent are overweight, according to the CDC.

Setting up the anti-obesity agency was one of many recommendations in the New Jersey Obesity Prevention Action Plan, written by a large task force established by the state Legislature.

Jacobs said the new agency will begin operations within weeks, and may be able to win more federal and private grant money. He said it will coordinate spending of more than \$2 million in nutrition and fitness programs, including promoting physical activity at all ages, providing fresh fruit and vegetables to eligible women, children and senior citizens, and encouraging breast-feeding, which can reduce the baby's chances of a weight problem later.

Other state agencies will be working with the health department.

The Agriculture Department, for example, has been boosting the number of farmers market bringing fresh produce to seniors and city residents whose local stores don't stock much produce, said its head, Charles Kuperus.

More than half of all schools have already complied with the department's new rules limiting the amount of high-calorie, high-sugar foods available, a strategy meant to prevent kids from bypassing nutritious lunches and getting french fries or snacks from vending machines, he said. Every school is expected to be in compliance by the September deadline.

Assemblyman Herb Conaway, who's also a physician, calls the new agency "an important step," much needed because the cost of caring for the chronic illnesses linked to obesity will strain both government and private insurance programs.

Sue Shapses, a Rutgers University nutritionist who heads a statewide group of researchers focused on obesity, said setting up the new agency is "very commendable," but said to succeed, it must focus on programs proven to work.

"With the right person in charge, this can lead to great changes in New Jersey and beyond," she said.

Jacobs said the agency has to do far more than just tell people to lose weight, given that genetics and other factors play a role in obesity. He especially understands the battle, having struggled with a weight problem all his life until undergoing surgery in December. He's since lost 85 pounds.

"I'm very close to where I would like to stop," he said. "I'm feeling great."

NJ Obesity Prevention Action Plan: http://www.state.nj.us/health/fhs/documents/obesity_prevention.pdf

The Obesity Society: <http://www.naaso.org/>

Contact Your AAP/NJ Headquarters

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