The Florida Pediatrician

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Florida Chapter American Academy of Pediatrics

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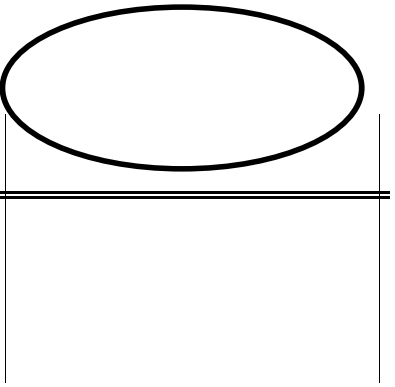
In this issue.....



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Gainesville, FL
(e-mail:buccirl@peds.ufl.edu)
Chapter President Elect
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Coral Springs, FL
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Ft. Lauderdale, FL
(e-mail:stardoc55@aol.com)
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EXECUTIVE OFFICE

Executive Vice President
Louis B. St. Petery, Jr., M.D.
1132 Lee Avenue
Tallahassee, FL 32303
(Ph)850/224-3939
(Fax)850/224-8802
(e-mail:lstpetery@attglobal.net)
Membership Director
Edith J. Gibson-Lovingood
(Ph)850-562-0011
(e-mail: edielov@cs.com)
Legislative Liaison
Mrs. Nancy Moreau
(Ph)850/942-7031
(Fax)850/877-6718
(e-mail: moreaurl@aol.com)

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(Florida Association of Adolescent Psychiatry)

E-Mail

Barrett, Douglas, M.D.
barredj@peds.ufl.edu
Bauer, Charles, MD
cbauer@peds.med.miami.edu
Benton, Thomas, MD
notneb@bellsouth.net
Berget, Bruce, MD
bbdocfl@aol.com
Blavo, Cyril, DO
cblavo@hpd.acast.nova.edu
Budania, Jyoti, MD
shalusona@pol.net
Christensen, Robert, MD
rchriste@hsc.usf.edu
Cimino, David A., MD
ciminod@allkids.org
Curran, John, MD
jcurran@hsc.usf.edu
Dabrow, Sharon, MD
sdabrow@hsc.usf.edu
Del Toro-Silvestry, Jorge, MD
Jorge_deltoro@pediatrix.com
Drucker, David, MD
david@druckermail.com
Friedman, Lawrence, MD
lfriedman@miami.edu
France, F. Lane, MD
flfrance@mem.po.com
George, Donald E., MD
Dgeorge@nemours.org
Gereige, Rani S., M.D.
gereiger@allkids.org
Giroud, Jorge, MD
72610.277@comppuserve.com
Griffis, Susan, MD
susangriffis@altavista.com
Granado-Villa, Deise, MD
deise.granado-villar@mch.com
Howell, Rodney, M.D.
rhowell@peds.med.miami.edu
Isaac, Jerome, MD
jhisaac@home.com
Junejo, Shakra, MD
Shakra_Junejo@doh.state.fl.us
Kairalla, Andrew, MD
abkair@aol.com
Katz, Lorne, MD
lokatz@mem.po.com
Lilly, Carol, MD
clilly@hsc.usf.edu
Meek, Joan, MD
Jmeek@nemours.org
Miilov, David, MD
dmilov@nemours.org
Ohring, Marshall, MD
MOhring55@aol.com
Pomerance, Herbert, MD
hpomeran@hsc.usf.edu
Reese, Randall, MD
randall_reese@hotmail.com
Rodriguez-Torres, Ramon, MD
rrtcorp@aol.com
Schwartz, Kimberly, MD
KSchwartz@med.miami.edu
Stenklyft, Phyllis, MD
Phyllis.stenklyf@jax.ufl.edu
Sussmane, Jeffrey, MD
Jeffrey.sussmane@mch.com
Toker, Karen, MD
karen_toker@doh.state.fl.us
Truman, Thomas, MD
trumant@tallynet.com
Waler, James, MD
jawaler@hotmail,com
Weiss, Charles, MD
cfweiss@pol.net
Werk, Lloyd, MD
lwerk@nemours.org
Whitworth, Jay, MD
jwhitworth@abusenet.org
Yee, Patrick, MD
Patyee1@tampabay.rr.com

Dear Colleagues

Congratulations are in order! First of all, I want to congratulate David Marcus, Edie Lovingood and Ann Groves on putting together an outstanding annual meeting. I believe we had in excess of 120 participants including alumni from the University of Florida, University of South Florida and the University of Miami. I am sure you agree with me that the speakers were outstanding and the environment very conducive to both education and to enjoying some time with family and friends. I can tell you that next year's conference will even be better with increased attendance and a superb line-up of speakers. I am truly pleased with the way our Chapter annual meeting has developed over the last several years, a direct result of a lot of hard work of many individuals and the vision and wisdom of Ed Zissman and others who suggested this format.

Congratulations are also in order for all of you as Chapter members who assisted us in developing our Chapter annual report. In recent months it came to my attention that many of you are involved in community activities throughout the state, yet the Chapter has had no way of cataloguing that involvement and bringing it together either in the annual report to the American Academy of Pediatrics or to other colleagues within the state. As we requested information regarding specific projects in the various regions, we were overwhelmed and pleasantly surprised how active all of you are despite all the roles of practice and long hours. You still have an enormous amount of energy and participate in myriad activities benefitting families and children that go way beyond our usual practice setting. Once again, without a doubt it is true that Pediatricians truly care for children and their families and not just other practice.

* * * * *

"..many of you are involved in community activities throughout the state..."

* * * * *

Because we want to make sure that we share this information with everyone, we have added an additional supplement to this newsletter highlighting these programs throughout the state. You will see in the near future we will add an additional column to each of our newsletters highlighting a new program or updating you on the programs that are mentioned in this article. It is important that we share this information with each other so that we are aware of the tremendous contributions members of our Chapter are making at the local level and so that you will perhaps learn from others' experiences and be able to implement, when appropriate, these programs in your area.

I must say that through all the battles we have had with funding in the legislature, it is very rewarding to realize how much we give to our communities and without a doubt we make a difference in the lives of many children and families. We will take this information and use it to educate our legislators on the very important contributions that you all make and hopefully they will begin to understand better the totality of the commitment of Florida's Pediatricians.

*(See **President**, page 31▸)*

FPIC ad

A Celebration Issue

Here we are just past July 4th, as ever a time for celebration. Since we should never miss an opportunity to celebrate, and since this is no exception, we have put together a "celebratory" issue of *The Florida Pediatrician.*

Number One on our list is a recognition of all that the membership has done for children, the society, and the community. The report was created from the annual report of the membership to the society. These accomplishments are so astounding that we felt that they should be broadcast, so that we can say thanks to all of the membership. If you will turn to the middle of the newsletter, you will find that we too can have a centerfold! And in its four pages are listed the many things our members have done. For those of you with the inclination, the centerfold was used because it is easily removable. Show it to your friends and colleagues. Brag a little for us!

"...brag a little..."

Listed are the very different kinds of things that members and groups have done, ranging from national awards to media programs to involvement with gun control, to CATCH grants. One of our resident members is the recipient of a sizeable grant from the Maternal and Child Health Bureau. One of our members has begun an outstanding adolescent program. The list goes on and on.

"...the list goes on and on..."

One of the accomplishments I am proud of is the continuing evolution of this newsletter. As I have pointed out repeatedly, this is not a one-person product. Actually, in the last 4 issues (one year), there were 43 members and others involved in supplying the outstanding material it contained.

A second event is the successful defense against passage of the bill in the State Legislature which would have mandated eye examinations for newborn infants. We tried to make everyone understand that we certainly are very interested in infant problems, and believe we are capable of solving these problems without legislation, especially when this legislation would do little to improve the situation. In this connection, we had a highly professional scientific article on retinoblastoma, which helped to make all of our members more familiar, once again, with the disease.

"...the successful defense..."

Yes, we can celebrate, but we will not be a "flash in the pan". (For those too young to know, this refers to the flash guns of early photography, where magnesium was ignited in a long "pan".) I am absolutely certain that all these people, will continue, and other members, especially the younger members (our leaders of the future) will be inspired, to contribute to our future successes.

Fortunately, the Fourth has come and gone with safety for most of us, and we can now celebrate! Enjoy the rest of the summer!

- The Editor□

EDITORIAL OFFICE

Herbert H. Pomerance, M.D., Editor
Carol Lilly, M.D., Associate Editor
Department of Pediatrics
University of South Florida College of Medicine MDC 15
Tampa, FL 33612
(Ph)813/259-8802
(Fax)813/259-8716
e-mail: hpomeran@hsc.usf.edu
(Please address all correspondence, including

THE REGIONAL REPRESENTATIVES REPORT

(Each month, we provide reports from two of our eight regions)

Region VI reports:

With the exploding population growth in Region 6, provision of and access to medical care are ever greater issues. HMA (Health Management Associates) recently acquired East Pointe Hospital in LeHigh Acres, changed the name to LeHigh Regional Medical Center and is actively recruiting pediatricians. Just this month they received approval of a Certificate of Need to build a 100 bed new hospital in East Naples to provide services for residents of south Collier coounty and Marco Island. Concurrently the Cleveland Clinic Hospital in Collier County was denied a C.O.N. for 40 additional beds, based on inadequate access of all patiens to their facility. HMA also runs Charlotte Regional Medical Center.

More directly impacting pediatric subspecialty care in our district was the approval of a C.O.N. for transfer of 120 beds within the Lee Memorial Health System from Cape Coral Hospital and Lee Memorial Hospital to Health Park Medical Center in South Fort Myers which houses the Children's Hospital of S.W. Florida. The inpatient expansion will include additional PICU and Peds Oncology eds as well as a dedicated pediatric ER staffed by pediatric emergency medical specialists. Recruitment efforts are ongoing for pediatric medical and surgical subspecialists in all disciplines.

Access to quality care remains a critical and uncertain concern. The future of the highly successful trauma center located in downtown Fort Myers at Lee Memorial Hospital is questionable due to hemorrhaging financial losses. The Lee Coounty Commission has been approached with a proposal for a ½ cent sales tax referendum in the Fall election to fund these crucual lifesaving services. Just as "low pay" or "no pay" hampers access of our population to first rate trauma services during "the golden hour", so does low Medicaid reimbursement severely restrict access of infants, children and adolescents to quality pediatric providers. In Lee County as of 2/8/02 Medicaid listed 49 providers, 41 of whom are pediatricians. Of the 41, 8 are retired, not living in Florida anymore or not providing on-going care (e.g., radiologists). A second Medicaid roster names physicians who accept Medicaid assignment of new patients. There are only 25 physicians who accept Medicaid assignment of new patients. There are only 25 physicians listed of which only 6 are pediatricians. I believe these numbers speak for themselves.

Lastly comes the BIG ISSUE that ultimately threatens all Floridians' access to medical care - i.e., the runaway plaintiffs' malpractice bar. These lawyers impact the availability of medical malpractice insurance, practitioner career decision making (e.g., from avoiding ER call, to early retirement, to leaving the State) and ultimately the cost and provision of medical services. Tort reform is no longer an option but rather a necessity.

Respectfully submitted,
Bruce H. Berget, M.D.
Region 6 Regional Representative☐

Region VII reports:

The Broward County Pediatric Society is in its second full year. Current membership is at 78 pediatricians and pediatric subspecialists. At the May meeting of the Society, nominees for President-Elect and Secretary-Treasurer for 2002-2004 were ratified by the membership. They are Dr. Ana Hernandez and Dr. William Bruno, respectively, and will join Dr. John Wright, incoming President, as officers for the Society's second term.

"Tidbits", the official newsletter of the Broward County Pediatric Society, is in its third printing. Original articles have spoken to Oral Health, Early Intervention, county-wide Childhood Immunization Rates, Tuberculosis Evaluation, Hurricane Preparedness, Children with Special Needs, Sports Medicine Pearls, Abusive Head Injury, Infant Mortality, Endoscopic Craniosynostosis repair, Drowning and Child Maltreatment.

The Children's Services Council of Broward County (Cindy J. Arenberg, President/CEO) has been established with broad based representation from community leaders in education, law, social services and programs, public health, and input from the local pediatric community and medical school.

After a brief summer hiatus, the Society will resume its educational dinner meetings, which in the past have included medical topics, as well as issues of health care advocacy and policy.

Jorge DelToro-Silvestry, MD
Regional Representative☐

Note:

Visit our society's permanent website at:
http://www.fcaap.org
for all you want to know about our society, including a summary of The Florida Pediatrician.☐

Note:

Another summary of The Florida Pediatrician is on the website for the AAP. The URL is:
http://www.aap.org/member/chapters/florida.htm. ☐

Note:

If you are a Fellow of the American Academy of Pediatrics, you are automatically a member of the Florida Pediatric Society/Florida Chapter of the American Academy of Pediatrics, and you automatically receive *The Florida Pediatrician.* If you have not already done so, please pay your annual Florida dues, billed through the Academy Office. ☐

The Department of Pediatrics at Nova Southeastern University College of Osteopathic Medicine

Edward E. Packer, D.O., FAAP, FACOP
Chairman and Associate Professor
Department of Pediatrics

With the approach of August another academic year begins at our University, and 180 eager students arrive to begin their education in medicine. I arrived at Nova Southeastern University only one year ago, just in time to savor the excitement in the air at the beginning of the school year. Over this past year, I have had the opportunity to develop programs and curriculum for our students, interns, and residents in pediatrics. To witness the thrill that a third-year student expresses at having successfully visualized and diagnosed otitis media in a child makes me grateful for the unique opportunity I have as a physician educator.

The Department of Pediatrics at Nova Southeastern University plays a critical role in the mission of our College of Osteopathic Medicine, to produce primary care physicians. Pediatrics is incorporated into every aspect of the education of our students from the beginning of the first year. Our department plays a vital role in developing the curriculum for the first and second year curriculum. As students study anatomy and biochemistry, they are also being taught skills in physical diagnosis as they relate to infants and children. When they take their courses in preventive medicine, clinical correlation, and medical procedures students are taught how these subjects affect the care of children. Our first and second year students also spend time in pediatricians' offices to become familiar with the health care needs of young patients and have the opportunity to put their pediatric skills to use.


Nova Southeastern Campus

During the third year, students are required to complete two rotations in pediatrics. The first rotation is the traditional hospital pediatrics program. The second rotation is in an ambulatory pediatrics clinic where primary care is emphasized. In the ambulatory clinics, the students participate in primary pediatric health screening and the care of children with outpatient illnesses. All of our students are required to complete a rural rotation where community pediatrics is a major part of their program.

Our college is starting a new program for both the education and evaluation of students and residents. OSCE's (Objective Structured Clinical Examinations) are being developed in pediatrics. These examinations consist of clinical scenarios with actors who present the symptomatology. The students interview and examine the "patients" in an equipped examination room with a closed-circuit video camera. At the conclusion of the examination the student submits a focused History and Physical with differential diagnoses and recommended studies. The faculty then reviews the written and taped encounter, and a critique is given to the student. The OSCE has proven to be instructive to both our faculty, as well as our students. With our new video examination rooms and our experience in OSCE performance, Nova Southeastern University is being considered as one of the national sites for the future national licensure exam when the OSCE component will be incorporated into the exam.

The campus of Nova Southeastern University provides several opportunities for interaction with other schools offering study and services for children. In the Health Professions division we have the dental, optometry, physical therapy, occupational therapy, and physician assistant programs which all have special divisions devoted to pediatrics. The Center for Psychological Studies has innovative programs for children with problems ranging from post-traumatic stress to attention deficit disorders. The Baudhuin School houses one of the largest centers for children with Autistic Spectrum Disorders in the country. Our department of pediatrics is working to enhance our relationship with these programs and is utilizing these sites to provide opportunities to expose our students and residents to the health care issues of children with these special needs.

Research in various pediatric subjects is expanding as part of our department's agenda. In keeping with the mission of our college, most of the work is in areas related to children's primary health care issues. Many studies are done in collaboration with other schools on our campus such as the Family Center for early child development. A number of our students are matriculating for a combined degree as a D.O./M.P.H. Dr. Cyril Blavo, who is a pediatrician, heads the Public Health School at Nova Southeastern University. Under Dr. Blavo's direction, many of the studies from the Public Health School are on pediatric issues. We are fortunate that Dr. Deborah Mulligan-Smith of the Center for Child Health Policy has recently joined our faculty and has brought her staff and organization to be housed on our campus. The Center for Child Health Policy has been instrumental in providing awareness to both health care providers and health care policy directors about important issues that affect children in our community.

Students at the College of Osteopathic Medicine participate in various aspects of community service. We have a very active Pediatrics Club that is involved in both educational meetings and many community outreach activities for children in our community. The student members participate in community health fairs, organize charity functions for needy children, and volunteer in local community hospitals to provide comfort and cheer to pediatric patients. The DOctor's bag

*(See **Chairmen**, page 30 ▸)*

Collaborative Research and PROS

Report

Forty pediatricians from 22 practices in Florida participate in the PROS network. Four Florida practices were among 130 nationwide to participate in the Life Around Newborn Discharge study (concluding in August). Two Florida teams participated in the national collaborative "Improving the Care Provided to Children with ADHD." The accomplishments of this collaboration will become part of the AAP's eQUIPP. Two new studies, Safety Check and CARES, will be launched soon. Safety Check will test a new, brief screening and counseling tool for either violence prevention or reading promotion and CARES explores how PROS practitioners approach the challenge of identification of child abuse.

Each AAP Chapter is invited to have a Chapter Coordinator and an Alternate Chapter Coordinator. Both representatives facilitate recruitment to PROS projects through speaking at local society and staff meetings. They are available as a resource to clinicians involved in a PROS study. Twice annually, one of the two representatives meets with other states' chapter coordinators and the PROS staff in a two-day workshop. New research protocols are reviewed for clinical relevance and practicality and the progress of projects are reviewed. Any active PROS member can participate with a research project at any level in the network including designing a study, co-authoring a journal article, collecting patient data, etc. In Florida, as FCAAP Chapter Coordinator, I report on Florida PROS network activity at each Executive Committee meeting and through this column in the Chapter's newsletter. FCAAP needs an Alternate Chapter Coordinator – if interested please contact me.

Despite having a network of 1600 practitioners in nearly 600 practices across the country, new practices are always welcomed to join. It takes our participation to ensure the findings of studies will be important and relevant to us. Upcoming PROS studies will test new resources to help busy clinicians promote child safety, aide in child abuse recognition, learn from errors made in ambulatory pediatrics, and better define what goes into a patient visit. If you are interested in partnering at any level (enrolling patients to designing projects), contact us at pros@aap.org or call 800-433-9016, extension 7626. Further, please contact me if you are interested in having a 12 minute slide presentation about PROS at your local hospital or pediatric society meeting.

Lloyd N. Werk, MD, MPH, FAAP
Email: LWERK@nemours.org
321-841-2036☐

From the Senior Section

[This excellent article is reprinted from the Senior Bulletin (AAP Section for Senior Members). It says a lot!]

Senior Pediatricians in Action as Advocates

Don Schiff, MD, FAAP

In the March issue of the Senior Bulletin, Jack Levine, a former teacher and urban youth counselor, described the powerful and effective job that he and his organization, the Center for Florida's Children, have been doing in that southeastern state.

His call for volunteer help is an insight into the actions of many of our own senior pediatrician advocates. When the Academy of Pediatrics Senior Section was being formed over a decade ago by Bob Grayson, Bill Daniels and others, they recognized the potential of this group as an unparalleled resource of energy, wisdom and experience in furthering the well being of our nation's children.

To support and give well deserved publicity to their endeavors, the executive committee of the Senior Section recommended to the AAP Board of Directors the creation of an award to give proper significance to their work. The AAP Board of Directors was pleased to approve our proposal, and the first award will be announced at our Academy fall meeting.

My purpose in providing our readers with a brief history of the Advocacy Award is to bring into focus and share with you the true stories of the exceptional work which your colleagues have been carrying out during the past decade. Bringing quality pediatric health care to children previously not able to access care is clearly one of our major Academy goals. Pediatricians led in Kentucky by Don Cantley are utilizing a mobile van as one of their approaches to outreach. By going to their patients in their neighborhoods most of whom have no health insurance, has enabled them to help hundreds of children who otherwise would be without access to health care.

Some of our fellow pediatrician advocates have enormous energy and have been able to utilize their expertise in their communities. Joe Davis, who spent his career caring for children at the Palo Alto Clinic, is one of those who found time to serve in a variety of roles including his local Boy Scout troop and helping children learn to read in an early literacy program. He is currently volunteering at the Redwood City Free Clinic.

In Mississippi, Bill Sistrunck has been active in community and state legislative affairs for 40 years, and for the past 20 years has become familiar to each state legislator. His commitment has led to a number of laws which have benefited the children of Mississippi, including mandatory seat belts, pick-up truck safety, and increasing the driver age to 16. He has served as a medical information source that legislators have come to rely upon for last minute details.

We salute these advocates for their devotion to children. Every community has one or more senior pediatricians who are actively working to help children. Many of you have experience which can enrich our knowledge base and help others find meaningful ways to utilize their own desire to help children.☐

Tumor-Induced Osteomalacia

Dorothy I. Shulman, M.D.
Associate Professor of Pediatrics
University of South Florida, Tampa

Introduction

Tumor-induced osteomalacia (TIO) is a rare disorder characterized by phosphaturia, hypophosphatemia and osteomalacia, mimicking either X-linked or autosomal dominant hereditary hypophosphatemic rickets. TIO is caused by tumors that are predominantly of benign mesenchymal origin. Surgical removal of the tumor relieves all symptoms; however, such tumors are often difficult to locate. Secretion by the tumor of a factor(s) turned "phosphatonin" causing renal tubular phosphate wasting has been proposed as the pathologic mechanism. Fibroblast growth factor (FGF)-23 is a peptide hormone that has been determined to be mutated in the autosomal dominant hypophosphatemic rickets and is over-expressed by tumors causing TIO. We present a young boy with severe rickets due to TlO in which a tumor was not identified by standard radiologic methods but was ultimately found with magnetic resonance (MR)/gradient recall imaging. We also describe FGF-23 mRNA levels in the tumor (a hemangiopericytoma), and serum FGF-23 measurements before and after tumor removal, further implicating FGF-23 as the causative factor in TIO.

Case Report

An 11-year-old Hispanic male presented with a femur fracture after falling from his bicycle. Severe bone demineralization was evident. He had complained of bilateral knee pain for a few years, but had no other health problems. Historically, linear growth had been steady above the 40th percentile. His legs were straight. There was no family history of rickets. On skeletal survey there was diffuse bone demineralization. A 2 cm defect was seen in the right proximal tibia, thought to represent a non-ossifying fibroma. Blood work was remarkable for hypophosphatemia, hyperalkaline phosphatemia, and very low levels of circulating 1,25-hydroxyvitamnin D, despite normal 25- hydroxyvitamin D concentrations (Table 1). Renal tubular reabsorption of phosphate was low at 71%. Bone mineral density (Hologic QDR-4500SL) of the lumbar spine was low at 490 g/cm2 (z score -2.3). The patient was started on oral phosphate and calcitriol minimal effect on the biochemical abnormalities except for a slight rise in 1,25-hydroxyvitainin D concentrations. TIO was suspected. Technetium bone scan and computerized tomography (CT) of the head, neck, chest, abdomen and pelvis did not reveal an obvious tumor, other than the defect in the right proximal tibia. This lesion, a non-ossifying fibrorna, was removed with no effect on hypophosphatemia. Tumor was analyzed for FGF- 23 mRNA and was negative. The patient became wheelchair bound due to leg and foot pain and weakness. MR skeletal survey using inversion recovery was attempted and showed an area of increased signal in the upper right femur. Focused plain film of this area was unrevealing. Gradient recall MR sequences, in and out of phase, highlighted around 3 cm lesion with smooth borders in the left iliac wing. Focused MR of the area of the upper right femur did not reveal a specific abnormality. The patient had a second operation removing the iliac tumor. Serum phosphate and 1,25-hydroxyvitamin D levels rose within 48 hours (Table 2). The patient spontaneously described feeling stronger. Pathologic diagnosis was hemangiopericytoma (Figure 1). FGF-23 mRNA levels were clearly measurable in the tumor. Serum levels of FGF-23 were elevated preoperatively (Table 2) and declined dramatically at 24 and 48 hours. Renal tubular reabsorption of phosphate increased to 88% at 41 hrs. The patient was walking within a few weeks of surgery. Six months later bone mineral density of the spine had increased 23%.

Table I.
Serum levels at baseline and during treatment with oral calcitriol and phosphorus

Treatment (Daily doses)	Time from presentation	Phosphorus (mg/dL)	Calcium (mg/dL)	Alkaline phos. (U/L)	25-vitamin D (ng/mL)	1,25-vitamin D (pg/mL)	PTH (pg/mL)
--------	Baseline	1.7	10.1	691	27	10	50
--------	Baseline	1.9	10.5	742	29	10	44
Phosphorus 500mg Calcitriol 0.5µg	1 mo.	2.5	10.7	1035	21	8	
Phosophate 1000mg Calcitriol 0.5µg	3 mo.	1.6	9.6	766			47
Phosphate 1000mg Calcitriol 0.75µg	5 mo.	1.7	10.2	729	18	43	71
Removal of non-ossifying fibroma	5 mo.	2.0	9.9	615		10	
Meds stopped	6 mo.	1.6	9.8	1004		24	
Phosphorus 1000mg Calcitriol 0.75µg	8 mo.	1.7	10.4	852	18	21	65
Phosphorus 1500 mg Calcitriol 1µg	11 mo.	2.0	9.3	1231	46	24	67

Methods

A General Electric Signa 1.5 Tesla Echospeed MR unit was used for the MR sequences. The tumor was identified using an experimental protocol (courtesy of J Farber) using gradient recall sequences, in and out of

*(See **Scientific**, page 28 ▸)*

Report on the 2002 Legislative Session

Nancy Moreau
Legislative Liaison

The 2002 Legislative Session, or should I say season, was one of the most trying the Society has experienced in many years. Our trials began with the terrorist events of September 11, 2001 which caused a downward spiral for Florida's economy as tourists chose not to travel fearing ongoing tragedy would plague this country. With an economy greatly reliant on tourist dollars and those dollars diminishing month by month the State undertook a torturous exercise of cutting programs to operate within existing revenues. Most children's programs did not suffer cuts nor was the Medicaid fee increase of last session withdrawn, however, great effort was needed to maintain the status quo and once again the state of the State did not allow the Society's priorities, to increase Medicaid reimbursement and reform the Kidcare program, to move forward. Interest of legislators and the Governor shifted to maintain essential services with no enhancements. The 9/11 event weighed heavily on the State as the realization that greater security measures would have to be established and the role of the Department of Health would have to be better supported. These events which took place prior to the start of the Regular Legislative Session foreshadowed one of the most politically contentious sessions that I have witnessed in over thirty years.

The differing philosophies of the Senate President and Speaker of the House; redistricting which takes place every ten years; declining state revenues; and, upcoming legislative, congressional and gubnetorial elections made the game playing all the more difficult for those whose agendas were nonpolitical. To top all of this off the Society had to defend its position on dilated infant eye screening against a tide of support generated by a grandmother who lost her grandchild to cancer and was convinced that her recommended screening techniques would save all children from her grandchild's fate and would cost little or nothing. The outright abuse heaped upon Society representative was maddening. This legislation would have passed had it not been for the pragmatic views of "friends" who were in strategic positions.

Thank you to all who responded to our requests for input and contact on issues, it makes all the difference when legislators hear from their constituents, and to Drs. Bucciarelli and St. Petery who were tireless, despite unjustified abuse, and, to Paul Wharton and Brian Jogerst for their savy counsel and continued commitment to children and the pediatricians who care for them.

The following bills were enacted during either the Regular or Special Legislative Sessions of 2002.

HB 59E - Health Care / Medicaid

(Chapter No. 2002-404) Effective Date: June 7, 2002

This legislation contains a multitude of provisions affecting the operation of the Medicaid program and other health care issues to include:

The Medicaid Integrity Program within the Agency for Health Care Administration and the Department of Legal Affairs' Medicaid Fraud Control Unit are given additional responsibilities to enhance the effectiveness of Medicaid fraud, abuse and overpayment oversight and recoupment. Whistle blower protection is provided to employees of Medicaid providers who report suspected cases of fraud or abuse to the hotline or the hotline of the Department of Legal Affairs. Medicaid recipients will be required to consent to the release of their medical records for fraud and abuse investigative purposes. New provisions regarding penalties and sanctions are established.

The Kidcare program is modified to eliminate the local match requirement for Title XXI eligible children. Intent language is added to state that local funds are to be used to expand coverage to children not eligible for federal matching funds under Title XXI. Entities allowed to provide local match include both government and private organizations and providers. Two additional members are added to the Florida Healthy Kids Corporation Board representing urban and rural counties.

Due to the demand for cutbacks in the Medicaid program, modifications have been made to several of the program components. Authority to contract with children's provider networks for care coordination and care management for pediatric patients is expanded to include pediatric emergency departments' diversion programs and Children's Medical Services Networks. Mandatory assignment to providers for those who do not make a choice has been changed to 55 percent managed care and 45 percent Medipass. However the definition of "managed care" now includes the Children's Medical Services networks, exclusive provider networks, provider service networks and pediatric emergency department diversion programs. The pediatric emergency department diversion programs will receive priority for assignment of children until such networks attain and maintain an enrollment of 15,000 children. Within the Medically Needy program, medical expenses used to meet the spend-down requirements will no longer be reimbursed by Medicaid. Dental coverage for adults will be limited to emergency dental care which includes emergency oral examinations, necessary radiographs, extractions, and incisions and drainage of abscesses. Adult visual and hearing services will continue to be covered by Medicaid.

Definitions are modified under the facility license law to allow teaching hospitals (408.07(44), F.S.) to be issued a single license, at their request, covering facilities with in a reasonable proximity as a single integrated hospital.

Nursing home liability issues are addressed in this legislation.

The definition of "home medical equipment" has been modified to exclude certain devices.

Other governmental entities will be allowed to provide the state share of Medicaid payments.

The pharmaceutical expense assistance program for seniors is modified to include individuals between 88 and 120 percent of the federal poverty level. The agency for Health Care Administration is to design annual per-member limits and cost-sharing provisions.

The Agency for Health Care Administration is required to implement a wireless handheld clinical pharmacology drug information for practitioners. Reduction of fraud, abuse and errors in the prescription drug benefit program must be part of the program design.

The Agency for Health Care Administration in cooperation with the Division of Children's Medical Services must conduct a study of health care services provided to medically fragile or medical

*(See **Legislative**, page 29 ▸)*

Report of Committee on School Health and Sports Medicine

Rani S. Gereige, M.D.
St. Petersburg, FL

Children between the ages of 5 and 18 spend a significant amount of their time in school, making school health a vital part of a pediatric practice. Pediatricians are at a perfect position to play a major role in School Health in their communities. As the newly appointed chairman of the AAP Florida Chapter Committee on School Health and Sports Medicine, I would like to introduce myself to you, offer my support and encourage each and everyone of you to participate in school health activities at various levels, based on your interests and expertise.

First, I would like to extend a word of appreciation and recognition to Dr. David Cimino, the past Chairman of the Committee and thank him for his dedication, support, leadership and vision. Dr. Cimino continues to play a major role in School Health issues as consultant to the schools, advocate, and role model for many young physicians. In addition, he has been instrumental in enhancing residents' education and exposure to school health through the provision of care in a school-based clinic setting. From patient care, to provision of consultation to schools, to educational activities geared toward school personnel, Dr. Cimino has given all of us an example of the many facets in which the primary care provider can be involved in schools. Thank you, Dr. Cimino, for your dedication and continued school health involvement.

As a general academic pediatrician, I firmly believe that collaborative efforts between the health and the educational systems are a successful recipe that makes perfect sense. We have seen that the only way immunization rates were increased was by linking immunization to school entry; a perfect example of successful collaboration. Through my interest in school health and sports medicine, I implemented school health and sports medicine elective rotations for the University of South Florida pediatric residents in an attempt to prepare the future pediatricians for involvement in their communities. I also try to get involved in educational programs for teachers and school nurses every time I get an opportunity to do so. I hope that I can help foster collaboration and bring forward important health issues that impact our children, which can only be addressed by working with the schools.

Several issues face our youths including: Safety, violence, nutrition, obesity, physical fitness, access to health services, substance abuse, as well as issues specific to children with special health care needs. School health services complement the pediatricians' efforts in addressing these issues through education, advocacy, and provision of service. In a survey published in *Pediatrics* in April 1999, more than 70 percent of the pediatricians surveyed want to become more involved in school health programs and they wanted more information and training to help them participate. Most of the 1602 respondents supported comprehensive school health education such as pregnancy prevention (82%), and violence prevention (77%). A majority supported the idea of health services in the schools, such as counseling (76%), nutrition (65%) and school-based primary care (58%). Two thirds believed that school-based clinics were one of the best ways to reach underserved children and adolescents and should include preteens. Pediatricians can serve in one or more of the following roles: Advisor, trainer or consultant, advocate, referral agent, recipient of referrals, communication link for parents and schools, health educator or promoter of fitness and nutrition wellness programs in schools.

The seven skills that pediatricians should develop when working with schools include:

1) Consulting with schools on health issues.
2) Drafting and revising school policies.
3) Consulting with schools about health education.
4) Communicating health messages.
5) Serving on school health advisory councils.
6) Assessing community needs and determining service parameters.
7) Evaluating the effectiveness of school health programs.

I am certain that several of you are currently fulfilling one or more of the above roles in working with the schools in your community, at the state and national

levels. I also hope to create a core group of committee

(See **School**, page 31 ▸)

Managed Care

Ramblings and Rumblings from the FCAAP Practice Support Committee

Edward N. Zissman, M.D.
Immediate Past President
Altamonte Springs, FL

Note:

The Florida Pediatrician has had and continues to have a policy to print an article on Managed Care in each issue. This policy will be adhered to so long as suitable articles are submitted. Both sides of the issue will be represented.

Publication of an article does not indicate any endorsement of the opinion by *The Florida Pediatrician* or by the FCAAP/FPS.□

Not much new to report from the third party payers. United Health Care's rescinding of authorization for most referrals has eased pediatricians' burdens.

Many third party payers are moving toward increasing internet applications including verification of eligibility, claims status, and referral authorization. Some of these applications are much more mature than others.

The FCAAP, with major support from, and in collaboration with, the FMA, successfully educated the legislative leadership to increase Medicaid reimbursement for patients ages newborn to twenty–one years. The increase this year was a modest four per cent for all CPT procedure codes for this age group regardless of physician provider. Our stated goal is to move these fees to at least Medicare reimbursement levels and then to bring all Medicaid recipient reimbursement to this level regardless of age.

The increase was effective April 1, 2002 which allowed the legislature, this first year to appropriate only twenty five per cent of the funds required for annual implementation. While carefully reviewing the first EOB's that reflected the April procedures, it became readily apparent that the reimbursement for CPT codes 99212, 99213, and 99214 failed to reflect the increase. The Chapter leadership brought this to the attention of the appropriate authorities and this bureaucratic misinterpretation was promptly corrected. A review of the incorrectly paid reimbursements is currently underway and the underpayments should be reimbursed in the next several weeks.

Florida Medicaid will be moving toward HIPPA compliance. They have circulated a communication plan to implement provider awareness. The plan includes:

- maintaining the Medicaid HIPPA website: www.fdhc.state.fl.us/Medicaid/hippa;
- conducting a survey of Medicaid providers to determine their progress towards compliance with the EDI portions of HIPPA;
- producing a HIPPA provider newsletter;
- developing provider training modules for Medicaid area office and ACS field representatives;
- installing a list service for providers to receive e-mail alerts regarding HIPPA developments;
- revising the reimbursement and coverage and limitations handbooks to reflect changes in Medicaid's business processes necessitated by HIPPA regulations. The gap analysis and requirements analysis of the remediation contract will determine the scope of changes in each of the handbooks;
- updating the Medicaid billing software offered by ACS State Healthcare. The updated software will be HIPPA data compliant and is scheduled for delivery prior to October 2003.

Finally, Well Care HMO (parent company of both Healthease and Staywell) which is thought to be the largest third party administrator of managed pediatric Medicaid services has been purchased by an outside investment group. Stay tuned for what changes this might bring to the pediatric providers who provide

medical care to the pediatric patients covered by this organization.□

From the Resident Section

Laura P. Stadler, M.D.
Chief Resident, USF Residency Program

[In each issue, we will focus on the State's Residency Programs and/or on issues affecting all programs.]

National Highlights

Resident Work Hours:

The Accreditation Council for Graduate Medical Education has announced new requirements with regard to working conditions for residents, with a goal of June 2003. The AMA has supported these changes and the Resident Section is writing letters and lobbying to support these requirements.

- Hours are limited to 80 hours/week
- Residents must have a minimum rest period of 10 hours off between work periods
- Continuous time on duty is limited to 24 hours, with additional time up to 6 additional hours for inpatient and outpatient continuity, transfer of care, educational debriefing and formal didactic activities

For more information, see www.acgme.org/new/residentHours602.asp

Pediatric Match Results: Should we be concerned?

90.5% of PGY-1 Pediatrics positions filled in March 2002, compared with 96.7% in 2001. 72 programs in Pediatrics did not fill, compared with 32.

Question: Should we be doing more to recruit US medical students to the field of Pediatrics?

District Resident Executive Committee At Work:

There is a biannual publication, with next publication due in the Fall, 2002. Look for articles from Joe Jung, DO (life as a neonatologist) and Laura Stadler, MD (Pediatric Match Results: The Pendulum Swings).

We are in the process of Updating the Resident Section of the AAP web page! New links include:

-Boards link: re: application, timeline of boards, & review courses (practical information)

-Jobfind: How to look at contracts, timelines, approaches

-Fellowship Link: timelines, basic ways to start your search

-Awards, including CATCH and Travel Grants

-Advocacy and Legislative Link

-Awards: Application for the Outstanding Resident of the district: including volunteer and community leadership, research, case presentations, "team players"

-FAQs

Medical Students: How can we better get them involved?

Florida Section

Thanks to our State Leaders for the support and encouragement to our section. We are fortunate to be supported in many ways including funding of our teleconference calls and membership. Many states aim to have the communication and identity that we have in Florida.

A Special AAP award was given to Joe Jung for his leadership dedication and service to children. Joe served as the first Florida Chairperson and really got our section started. He also currently serves as the District X Coordinator. Congratulations!

"The AAP and You" Power Point Presentation is available on line through the website. It has also been e-mailed to program representatives and Program Directors. Please select a person involved in the AAP in your area to give a noon conference in July. The goal is to give this talk early so that the interns hear it and get acquainted with the AAP. Also, it's important to introduce AAP as CATCH grants are due July 26th and people may want to plan for the national meeting in Boston (October).

AAP Flyers will soon be available. They are currently being edited for distribution at the above meeting. Details to follow.

Advocacy: Please try to address Increasing Physical Fitness/Obesity: our goal for the year. This may seem to be "small" [redacted] group, School/Sports physicals, noon conferences are easy suggestions to address this and get involved

Future Events

Election of 2002-2003 Florida Chairperson of the Resident Section Committee on July Conference Call: Wednesday July 17, 2002 at 9pm.

CATCH Grant applications due July 26, 2000. Residents may be awarded up to $3000 in funding. Applications may be obtained (and submitted) on line or on the "old fashioned, traditional" paper.

BOSTON: Annual AAP meeting: October 19-23rd, 2002. Register at
http://www.aap.org/nce.htm early for discounted rate

Welcome new interns! Have a great year!

Thanks.

Laura Stadler, MD lpstadler@hotmail.com□

University of Florida, Gainesville

During this past academic year we have incorporated numerous programs that we feel have added valuable learning experiences for our residents. One of these programs is the Home Visitation Program. This is a service where residents choose patients from their continuity clinic whom they feel would benefit from having health care brought to their home. The visit incorporates traveling with a medically equipped van to the patient's home to perform well child

check-ups as well as other needed services such as immunizations. Not only is this of value to patients, especially those with transportation difficulties, but it also helps the residents better understand their patient's socio-economic status that might not otherwise have been appreciated. Another new addition is developing access to our morning report cases online. This provides a more interactive approach to our morning report. Residents learn how to search for evidence-based medicine to answer questions that may arise from the case presentation. The morning report website can be accessed through our home page at www.peds.ufl.edu and then linking to "residency", "links" and "morning report" (and we welcome any feedback regarding our cases). One of our goals for this year is to develop a more structured advocacy curriculum. Through this we plan on developing an outreach program to the local schools to address issues such as the growing problem with childhood obesity.□

Risk Management

[The Florida Physicians Insurance Company (FPIC) is endorsed and sponsored by the Florida Chapter of the American Academy of Pediatrics as its exclusive carrier of malpractice insurance for its members. In each issue, FPIC will present an article for our readers on matters pertaining to risk management]

Medical Records and Documentation

Cliff Rapp, LHRM
Vice President Risk Management, FPIC

In virtually every discussion of medical malpractice risk management, the critical importance of keeping accurate, complete records is stressed. Yet in spite of these constant admonitions, large numbers of physicians continue to be perilously lax in their record-keeping procedures. Medical records serve two purposes: communicating essential information among the healthcare team, and providing a permanent written record of treatment and the facts and reasoning behind the chosen treatment.

The necessity for good medical records should be obvious to all physicians. The volume of patients and the length of time between their visits make good records essential to the continuing care and treatment of patients. However, you must realize the need for good record keeping has become even more important in the face of the increasing frequency and severity of liability claims. In the event a lawsuit is commenced, good records can be a physician's best ally and, in most cases, they form the basis of the defense.

In evaluating a potential liability claim, one of the first steps taken by a plaintiff attorney is a thorough review of the medical records. Many times good medical records prevent the case from ever going beyond this stage. Obviously, if the records indicate the course of treatment given the patient was justified or the result complained of was merely a risk inherent in the procedure performed, the chances of a plaintiff attorney actively pursuing the claim are slight. On the other hand, incomplete or inaccurate records may not only precipitate a lawsuit that could have been avoided (through proper record-keeping procedures), but will often significantly contribute to a successful verdict for the patient.

If you keep several basic points in mind when preparing medical records, you can greatly improve the quality of your records and substantially reduce the possibility that these records will be unjustifiably utilized against you in litigation.

First, all entries should be made promptly in a clear, legible fashion or dictated. The longer you wait, the greater the chance for error.

Second, you should constantly strive to maintain the proper information in your records. A good rule of thumb is that the records should contain whatever you, as a consultant or subsequent treating physician, would need to acquire for

an understanding of the patient's history and to effectively commence treatment.

Likewise, in a case in which you deviate from the usual course of treatment, it is always helpful if you record the reasons for your deviation. Also, when a medical "trouble situation" develops, a physician should document the crisis carefully, objectively, and as thoroughly as possible. Note the efforts, the diligence, and alternatives considered. If appropriate, note the fact that a consultant was called and the action taken. As important as what medical records should contain is what they should not

contain. The guiding principle is relevancy. You should guard against inclusion of unnecessary or gratuitous comments. For example, irrelevant personal observations about the patient's personality should be avoided. Likewise, the records should not be used to criticize other physicians or hospitals. Most importantly, physicians should not record unwarranted admissions of liability in cases in which an adverse result is achieved.

No matter how careful you are in your record keeping, there will invariably be times when you discover that an inaccurate entry has been recorded. In this case, you should be extremely careful in correcting the inaccuracy to avoid even the slightest implication that the records have been tampered with. The best way to correct the error is simply by drawing a single line through the inaccurate original entry, initial, and date; then enter the correct information. It is far better for the record to show that a record-keeping effort has been made and corrected than to allow the suggestion that the records have been altered by obliteration.

In a liability action, once the suggestion of record tampering is successfully made, the physician's credibility is almost always injured beyond repair. This destruction of the physician's credibility leads most often not only to a successful verdict for the patient, but also to a verdict far in excess of what would have been awarded without evidence of altered records.

Complete medical records, written at the time you have contact with a patient, are your best defense against a malpractice action. Good records can unmask the non-meritorious claim, often before it reaches the courtroom. Poor records on the other hand can make even a non-meritorious claim impossible to defend.☐

Special Section

or

Let's Brag a Little!

[Our President and Executive Vice President received the following from members on request for information for the Annual Report of the Chapter to the American Academy of Pediatrics. The responses were so impressive that it was decided to compile them for the membership.]

From Steve Freedman:

For fifteen years the Ford Foundation and the Kennedy School of Government at Harvard University have selected ten programs per year to receive their "Innovations

in American Government Award".

This year, from all of the previous award recipients, 15 were selected as the most outstanding innovations in the history of the award. Florida's Healthy Kids Corporation was one of the programs selected. That program was authored by Steve Freedman, Ph.D., FAAP of the Florida Chapter.

From the Editor of The Florida Pediatrician:

The Florida Pediatrician flourished during the year 2001-2002, with quarterly publication in August, November, February and May.

The August 2001 issue comprised 24 pages. The May 2002 issue comprised 32 pages. At least 43 different pediatricians, and a few others, contributed to these pages. Features included:

- A Presidential message in each issue.
- An editorial by the Editor in each issue.
- A report from each of the Regional Representatives, two per issue.
- A committee report in each issue.
- A report from the PROS network in each issue.
- A report on Managed Care in each issue, representing both sides of the controversy.
- A article on Risk Management in each issue.
- A report from one of the Medical School Department Chairmen, initiated in February.
- A report from the Florida Resident Section in each issue.
- An excellent Scientific Article in each issue.
- A report from our Legislative Liaison, spread out in two issues, to summarize legislative progress in pediatric affairs in the last session.
- A report on CATCH from one of the two state facilitators, alternately.
- Special Articles by guest writers on subjects of concern to the membership. There were 8.
- News items of importance, transmitted from the AAP
- News items of importance from the Florida Chapter.
- "Pearls" from the chairman of the Committee on Environmental Health, Drugs and Toxicology
- A timely listing of regional and some national pediatric meetings.

Vendor support of the newsletter continues to improve.

From Patti Cantwell, Miami

I (or a designee) participate in the Gun Awareness Training and Education Program, (spearheaded by Mimi Sutherland) for upper middle-school and high school students involved with some event with a gun. They are brought through the PICU for exposure to critically injured children. I have done a yearly presentation at a community high school and provided continuing education for Emergency Services personnel (paramedics and firefighters), to educate in care of the critically sick and injured child.

Marisela Jaquez (Miami) reports:

Weekly one and a half hour radio programs are addressed to the hispanic lay audience through Radio Paz, the Catholic network, with audiences in Dade and Broward.

Medical missions to Caribbean and Central American countries are sent, with the participation of lay volunteers from our community, as well as UM/JMH students and residents. Physicians from other institutions collaborate too.

We are open to provide education and guidance to individuals and parents concerned about behavioral problems in two religious communities that I attend.

James Waler (Jacksonville) reports for Region II:

The primary activity in the past year for District II members is participation in planning and implementing the Healthy Child Care Jacksonville program. This program, which began with a CATCH grant, involves local

pediatricians volunteering to be a consultant for a child care center and provide monthly visits to discuss different topics, as well as remain available to address issues as they arise at the centers. This rapidly expanding program currently has almost 40 pediatricians and 20 pediatric residents assigned to different local child centers.

Lloyd N. Werk (Orlando) and Laura Stadler (USF, Tampa) report for the Resident Section:

The FCAAP Resident Section is dedicated to the principle of helping pediatricians-in-training promote a meaningful and healthy life for every child. The Section fosters early involvement in the AAP. Representatives from each of the seven Pediatric Residency programs in Florida discuss their activities and plans in monthly teleconferences hosted by the Chapter. These representatives meet in person at the annual national AAP meeting and chapter annual meeting. Two Executive Committee members, Lloyd N. Werk, MD, MPH, FAAP and Sharon Dabrow, MD, FAAP precept these young leaders. The current section chairperson is Laura Stadler, MD from Tampa, Florida. With their regular communication and sharing of resources, it is not surprising that the Florida resident section has a significant impact on these young physicians' growth. In the past year, the former chairperson, Joseph Jung, was elected to District leadership.

The residents in District 10 (including Florida) selected "Increasing Physical Activity/Obesity" as their advocacy target this year. Programs are addressing the issue in various ways in clinics, including handouts for each age group. Many residents are volunteering for sports camp and school physicals.

Primary investigator at USF, Beth Ann Gemunder, along with a faculty advisor, received a $10,000 grant from Healthy Tomorrows, an AAP partnership with the Health Resources and Services/Maternal and Child Health Bureau to obtain medical care/homes for children through the Lawton Chiles Community Health Center in Bradenton. "Reaching Children: Building Systems of Care (REACH OUT)" aims to gain access to medical care for children in Bradenton, FL. Beth Ann is one of several residents who participate in USF's Rural Track at the Lawton and Rhea Chiles Family and Child Health Center in Bradenton, FL.

The section will work on helping residency programs adhere to new work requirements and the assessment of educational core competencies.

Lawrence Friedman, at the Universityof Miami

The Division of Adolescent Medicine of the University of Miami School of Medicine has a successful social marketing campaign that I direct. Known as the "Gettin' Busy?" program, it seeks to identify HIV-infected 13-24 year olds in the Miami area by encouraging free oral HIV testing at selected adolescent-friendly community sites. We facilitate a partnership of HIV and/or youth-serving agencies that are affiliated with the Miami-Dade County Health Department's local Branch Laboratory of the FL DOH. Posters, TV and radio PSAs, urban/hip-hop/rap prevention music and performances, toll-free telephone line, and website all are included in the campaign, which has wide visibility throughout minority neighborhoods and South Beach areas. Check out the website at www.gettinbusyusa.com and the 1-877-HIV-TEEN telephone system.

Lee M. Sanders, U. Miami:

1. Reach Out and Read Miami

Thanks to support from the John S. and James L. Knight Foundation, Reach Out and Read Miami expanded this year from a single site at Jackson Memorial Hospital to nine sites in Miami-Dade County. The program now reaches 12,000 children under age 5 years, or about 15% of the target population pediatricians (including forty residents) have been trained in providing literacy guidance to families. The mission of Reach Out and Read is to make early literacy promotion a routine part of pediatric primary care three components are (1) pediatricians' giving anticipatory guidance about reading aloud; (2) pediatricians' giving free, developmentally and culturally appropriate books at each well-child visit from 6 months to 5 years; and (3) volunteers modeling reading aloud in the waiting room.

2. Pediatric Resident Advocacy Curriculum

2001-2002 was the first year of a required curricular module in Pediatric Advocacy for the interns at the UM/JMH Pediatric Residency Training Program. A total of 25 residents participated in the curriculum. Each resident chose a topic (ranging from healthcare access to breastfeeding promotion to teen pregnancy prevention to early childhood obesity), then met with community leaders to plan a meaningful, feasible way for them to take action. Each resident formally presented the results of this community exploration to their fellow residents in a 20-minute discussion session at the end of their rotation.

One more announcement: The Pediatric Residency Program at the University of Miami was awarded a 5-year grant from the Anne E. Dyson Community Pediatrics Training Initiative. Our mission is to establish a model advocacy program that will improve

child health through stimulating and self-sustaining innovative partnerships between pediatricians and community-based organizations in South Florida, and to instill in the minds of pediatricians-in-training the positive impact that such collaborative efforts can have on the lives of children. This mission will be accomplished through innovative didactic and experiential learning curricula being developed by pediatric faculty in partnership with community leaders.

Gaston Zilleruelo M.D., at the University of Miami:

I am happy to report that we have continued providing services to all children with reduced kidney function through the Children Medical Services, State funded program called CCKFC, which stands for "Comprehensive Children Kidney Failure Center". This program was instituted more than 25 years ago and represents a unique experience in the nation that certainly has improved our management of children with chronic kidney diseases. In a recent review of our experience here in Miami, combined with the University of Florida at Gainesville, we have accumulated a total of 1,569 children under 21 years of age with chronic kidney insufficiency, from which a total of 762 underwent dialysis therapy and 532 were transplanted. Currently, here in Miami, we have one of the largest Pediatric Dialysis Unit in the country with 34 patients on chronic hemodialysis and one of the best kidney transplant graft survival statistics according to UNOS. All these accomplishments have been made possible through the creation of these centers of excellence, now located at the University of Miami/Jackson Children's Hospital, University of Florida at Shand's and University of South Florida at Tampa General. I will be pleased to provide more information if needed.

Deborah Mulligan-Smith, President-Elect, reports:

1. NHTSA Walk Our Children to School project has been in effect for the past three years.
2. The continued academic relationship between the FCAAP and Mexican Pediatric Society includes an upcoming PEPP (The pediatric prehospital emergency provider course was originated through cooperation between Florida and CA physicians. www.peppsite.com PEPP is offered by the AAP Life Support Division worldwide.)
3. Deliver the Dream
4. BCMA - BCPS Drowning Prevention

Deliver the Dream

She doesn't understand being in the hospital and why her daddy can't fix everything and then we all go home. As health care professionals we know all too well that almost all families are touched by illness or crisis during the course of a lifetime, but some families are struck particularly close to home. When a child develops a life-threatening disease, or a spouse is diagnosed with a debilitating illness, the impact on the entire family is intense and often overwhelming. While there are camps that assist children in coping, there are very few facilities specifically designed to help the entire family gain strength, mend spirits and learn how to be families again. Deliver the Dream is a non-profit mountain retreat and enrichment center providing unique development experiences and support for children and families in crisis and individuals in need. The program was inspired by Pat Moran, president and CEO of JM Family Enterprises, Inc., a company that is ranked as the 18th largest privately owned business in the U.S. by Forbes magazine. Bill Cosby, PhD supports Deliver the Dream as national spokesperson. Country music artists Craig Moran, Jeff Carson and Suzy Bogguss sing to support the cause. Other special Deliver the Dream friends include Susan Sarandon and Goldie Hawn. More than 200 acres of beautiful landscape, majestic waterfalls, streams and mountain trails provide the perfect year-round setting for this unique mountain retreat.

Deliver the Dream is working now to open its doors in the Spring of 2002. Medical Advisory Board Members include Drs. Deborah Mulligan-Smith, Versa Myers and Ora Wells of the Florida and North Carolina AAP Chapters and Florida Diagnostic and Learning Resources Systems Director Karen Moffitt. Valuable AAP and Emergency Medical Services for Children (EMSC) policy statements, education programs and products are pillars in constructing the programmatic direction of the organization. Among these resources are the PEPP Course, Office Based Preparedness for Pediatric Emergencies, How to Prevent and Handle Childhood Emergencies, the Family Readiness Kit, Family Centered Care, Children with Special Health Care Needs Kit just to name a few.

Deliver the Dream meets a vital need for Florida families suffering from trauma -- a need that has been unfulfilled until now.

Lloyd Werk, Orlando, on PROs:

Forty practitioners from 22 practices in Florida participate in the American Academy of Pediatrics network Pediatric Research in Office Settings. Lloyd N. Werk, MD, MPH, FAAP from Orlando serves as chapter coordinator and shares information about the network at FCAAP Executive Meetings, presentations, and through a

column in the chapter newsletter *The Florida Pediatrician*. Over the past year, a practice from Pensacola, one from Pembroke Pines, and two from Orlando joined almost 130 practices across the country in the ambitious and arduous Life Around Newborn Discharge (LAND) study. Clinicians from these practices administered a series of surveys describing a mother's and neonate's readiness for postpartum hospital discharge. The information gathered is critical to understanding the relationship among maternal, pediatric, and obstetric perceptions & clinical judgements on readiness for discharge and resultant health outcomes.

Florida fielded two teams: the General Pediatrics Division of University of Florida in Gainesville and from Orlando, Orlando Regional Healthcare Pediatric Outpatient Department/Nemours Children's Clinic in the national collaborative, "Improving the Care Provided to Children with ADHD" sponsored by the AAP and National Initiative in Children's Healthcare Quality. As part of the collaborative, the joint Orlando Regional Healthcare Pediatric Outpatient Department/Nemours Children's Clinic team piloted materials to be included in an AAP toolkit. The accomplishments of this collaboration will be shared by the AAP via its new quality improvement program, eQUIPP. As the LAND study winds concludes, two new studies will soon be recruiting practices. Safety Check will test a new, brief screening and counseling tool for either violence prevention or reading promotion and CARES explores how PROS practitioners approach the challenge of identification of child abuse.

Medical Student Awards:

The Florida Chapter gives a certificate and an award of $500.00 annually to each of three medical students from the University of Florida, the University of Miami, and the University of South Florida, chosen for their outstanding academic performance in pediatrics.

John Curran reports on Subspecialty Membership:

Subspecialty members are active in issues related to chapter activities and to compensation, legislation, and to direct provision of subspecialty care. Perinatal members were active in disseminating material and providing input with regard to dilated eye exams for retinoblastoma, review of nursing and respiratory therapy staffing standards in NICUs, development of pediatric and perinatal standards for hospitals, to cite certain examples. Advocacy for increased access and Medicaid funding have benefited specialists including hospital based pediatric medical and surgical specialists throughout the state.

C.A.T.C.H. reports:

Florida pediatricians submitted 7 CATCH grant applications, and five were funded. These projects include primary care access programs, improvement of dental health, public-private collaborative asthma management efforts, and pediatric residential hospice program, and a Healthy Child Care America initiative. Two U Miami residents were awarded CATCH grants: Dr. Viviana Alvarado-Lavin for "Early Childhood Development, Medical Home and Healthy Child Care America" and Dr. Robert Karch for "Learn While You Wait".

Dr. Arthur Brito of Miami received a "Reaching Children-Building Systems of Care" grant for a Haitian-American SCHIP Access Program.

From J.D. Donaldson, Otolarygology colleague:

Sunshine Foundation, Baiwan, China: Travelled to Baiwan from Hong Kong in February and with Dr. Y.K.Wong from Hong Kong did all the medicals for this orphanage and arranged for care of problem cases outside of mainland China.

Africa: Traveled twice to Nairobi in past year to consult with Gertrude's Garden Children's Hospital in Kenya. Have assisted in preparing plan of development with CEO, Mr. Andrew Bacon, emphasizing an African solution with North American support (as opposed to North American solutions). Will be bringing over to Southwest Florida their Director of Outpatient Care this September to assist in evolving a workable transition to ambulatory care at both primary and tertiary levels. Will be returning in next six month to assist in establishing research programs to attract capital for malaria, HIV diseases, TB, Sickle Cell and Septic Diarrhea.

Mexico: Pediatric Otolaryngology will be on the program for the National Congress for first time formally. Will travel to Merida in October as Guest Professor.

Fort Myers: Doctors for Kids is a community based organization under the Florida Children's Trust, a 501(c)3 organization established to fill the void when Nemours abruptly departed Southwest Florida. The practice has stablized and continues to expand with three to six new physicians expected in the next six months. Group now has nine full time pediatric subspecialists and one part time. □

aventis ad

Aventis ad

[Because of importance, reprinted from Pediatrics 2002; 109:980-981]

AMERICAN ACADEMY OF PEDIATRICS

Policy Statement

Section on Ophthalmology

Red Reflex Examination in Infants

ABSTRACT. Red reflex examination is recommended for all infants. This statement describes the indications for and the technique to perform this examination, including indications for dilation of the pupils before examination and indications for referral to an ophthalmologist.

INTRODUCTION

Current American Academy of Pediatrics policy recommends eye examinations for infants and children at specified intervals during their development, including an examination to take place sometime during the first 2 years of life, stating: "Vision screening and eye examination are vital for the detection of conditions that distort or suppress the normal visual image, which may lead to inadequate school performance or, at worst, blindness in children. Retinal abnormalities, cataracts, glaucoma, retinoblastoma, eye muscle imbalances, and systemic disease with ocular manifestations may all be identified by careful examination."[1]

The policy further recommends that an eye evaluation for infants and children from birth to 2 years of age include examination of the following:

Eyelids and orbits;
External structures of the eyes;
Motility;
Eye muscle balance;
Pupils; and
Red reflex.

The red reflex test is used to screen for abnormalities of the back of the eye (posterior segment) and opacities in the visual axis, such as a cataract or corneal opacity. An ophthalmoscope held close to the examiner's eye and focused on the pupil is used to view the eyes from 12 to 18 inches away from the subject's eyes. To be considered normal, the red reflex of the 2 eyes should be symmetrical. Dark spots in the red reflex, a blunted red reflex on 1 side, lack of a red reflex, or the presence of a white reflex (retinal reflection) are all indications for referral to an ophthalmologist.

Concern has been expressed recently that diagnosis of serious ocular conditions, including retinoblastoma and congenital cataract, in which early treatment is essential for future ocular and systemic health, often is not made sufficiently early to minimize potential consequences of those conditions. This concern has led to consideration of legislation in several statesa mandating early pupil-dilated red reflex examinations in all neonates or very young infants.

Although in infants, pupils are easily dilated using various agents, significant complications have been sporadically reported with all commercially available dilating agents, including sympathomimetic agents like phenylephrine and anticholinergic agents like cyclopentolate hydrochloride and tropicamide. These complications include elevated blood pressure and heart rate,[2] urticaria,[3] cardiac arrhythmias,[4] and contact dermatitis.[5,6] However, pupillary dilation has been performed routinely for many years in almost all new patients seen in most pediatric ophthalmology offices, with no complications seen for years at a time, so this procedure appears to be very safe when performed in an office setting on infants older than 2 weeks. Similarly, premature infants' pupils are often dilated in the neonatal intensive care unit without significant complication, so dilation appears to be relatively safe even in very young infants.

The purpose of this policy statement is to suggest a guideline based on current knowledge and experience for examination of the eyes of young infants to minimize the risk of delay in diagnosis of serious vision-threatening or life-threatening disorders.

RECOMMENDATIONS

1. All infants should have an examination of the red reflex of the eyes performed during the first 2 months of life by a pediatrician or other primary care clinician trained in this examination technique. This examination should be performed in a darkened room on an infant with his or her eyes open, preferably voluntarily, using a direct ophthalmoscope held close to the examiner's eye and approximately an arm's length from the infant's eyes.
2. The result of a red reflex examination is to be rated as negative or normal when the reflections of the 2 eyes are equivalent in color, intensity, and clarity and there are no opacities or white spots (leukokoria) within the area of either or both red reflexes.
3. A positive or abnormal result of a red reflex examination (inequality in color, intensity or clarity of the reflection, or the presence of opacities or white spots) should be followed, in a timely fashion, by 1 of 2 actions:
   a. A red reflex examination preceded by pupil dilation with ≤1% tropicamide or ≤1% tropicamide/2.5% phenylephrine mixture or a 0.25% cyclopentolate/2.5% phenylephrine (eyedrop or spray), administered to each eye approximately 15 minutes before this examination.
   b. Examination by an ophthalmologist experienced in the examination and treatment of the eyes of young infants, including ocular fundus examination, using indirect ophthalmoscopy after pupil dilation.
4. Infants in high-risk categories, including relatives of patients with retinoblastoma, congenital cataract, congenital retinal dysplasia, and other congenital retinal and lenticular disorders should initially have a dilated

*(See **AAP**, page 30 ▸)*

Congratulations

...to Gerry Schiebler, who received an award from the American Academy of Pediatrics. Lou Cooper, President of the AAP presented a plaque:

Special Achievement Award
Proudly Presented to
Gerold S. Schiebler, M.D., F.A.A.P.
Florida Chapter, American Academy of Pediatrics
for Distinguished Service and dedication to the mission and goals of the Academy.
[See photograph, cover page]☐

Chapter Elections

The following members were elected to office and were installed at the Annual Meeting:

Region V: Lynette N. Ringenberg, M.D. (Tampa) was elected as Alternate Regional Representative.

Carol Lilly, M.D. (Tampa) was advanced to the position of Regional Representative, term 2002-2004.

Region VII: William E. Bruno, M.D. (Pembroke Pines) was elected as Alternate Regional Representative.

Marshall Ohring, M.D. (Hollywood) advanced to the positionn of Regional Representative, term 2002-2004.

Kudos to the outgoing Regional Representatives, for a job well done!

Region V: **Patrick Yee, M.D.**

Region VII: **Jorge DelToro-Silvestry, M.D.**☐

District Election Results

District X Chairperson: Dr. Charles Linder was re-elected.
District X Vice Chairperson: Dr. John Curran was re-elected.
District X Nominating Committee: Dr. Linda Anz was elected.

Note: In the 2002 National election, there were 40,077 ballots sent, and 11,581 were returned, representing a 28.9% turnout. The return for the Florida Chapter was 31%, better than the national average, but not good enough!☐

Congratulations...

...to Paul Wharton, Ph.D. on his election as Honorary Member of the Florida Pediatric Society/Florida Chapter American Academy of Pediatrics, for his contributions for the children of Florida.☐

MEMBERSHIP ALERT!

Do you know any pediatricians, Fellows of the Academy or not, who appear to have been overlooked by the Society, and are therefore not members? Contact the Executive Vice President or Membership Director. There are several kinds of membership in the Society:

Fellow: A Fellow in good standing in the American Academy of Pediatrics - automatic membership on request.

Member: A resident of Florida who restricts his/her practice to pediatrics.

Associate Member: A physician with special interest in the care of children.

Military Associate Member: An active duty member of the Armed Forces stationed in Florida and limiting practice to pediatrics.

Inactive Fellow or Member: Absenting self from Florida for one year or longer.

Emeritus Fellow or Member: Having reached age 70 and having applied for such status.

Affiliate Member: A physician limiting practice to pediatrics and in the Caribbean Basin.

Allied Member: A non-physician professional involved with child health care may apply for allied membership.

Honorary Member: A physician of eminence in pediatrics, or any person who has mede distinguished contributions or rendered distinguished service to medicine.

Resident Member: A resident in an approved program of residency.

Medical Student: A student with an interest in child health advocacy.☐

FYI

The AAP will no longer print the tax deductibility disclosure statement on the membership dues invoice. Since we are incorporated as a 501 (c) (6) organization, we are required by the IRS to notify our members of the amount of dues that can be deducted as a business expense:

Dues remitted to the Florida Chapter are not deductible as a charitable contribution but may be deducted as an ordinary necessary business expense.

However, 30% of the dues are not deductible as a business expense for 2001 because of the chapter's lobbying activity.

Please consult your tax advisor for specific information.☐

The *Ticked Off* Column.

If you are really "ticked off" about something in your practice or about medical economics in general, write about it and send it in. Any reasonable complaint will find its way into print!☐

More from the FCAAP

On June 26, 2002, the CDC updated information for us on the status of vaccines and their shortages. This information is essential to all of us who see patients. For further updates, keep in mind: http://www/cdc.gov/nip.

The status of current vaccines is listed here, (listed in order by sequence in Childhood Immunization Schedule)*

Vaccine	Shortage	Expected Duration	Temporary Change from Routine Recommendation
Hepatitis B[1]	No		
Diptheria, Tetanus, and Pertussis (DtaP)	No[2]		
Td	No[3]		
Haemophilus influenzae typeB (HIB)[1]	See note[4]		
Inactivated Polio (IPV)	No		
Measles, Mumps, & Rubella (MMR)	No[5]		
Varicella	Yes	August 2002	Yes http://www/cdc.gov/mmwr/preview/mmwrhtml/mm5109a6.htm
Pneumococcal (PCV)	Yes[6]	last quarter of 2002 or later	Yes http://www.cdc.gov.mmwr/preview/mmwrhtml/mm5050a4.htm
Hepatitis A	No		

* Note: Only those vaccines included on the recommended childhood immunization schedule are included in this update.

Note[1]: Two to four weeks are required to fill Hepatitis B/HIB combination (COMVAX) orders. Full availability should return by early summer 2002.

Note [2]: DTaP supply is sufficient to return to a five dose immunization schedule. However, additional vaccine is not available for ambitious recall or special initiative programs at this time. There are now three DtaP vaccines (Tripedia, Infanrix, and DAPTACEL) distributed in the U.S.

Note [3]: Td supply is sufficient to return to the following: 1) routine immunization as recommended by ACIP/AAP, and 2) reinstatement of the administration of Td booster doses.

Note [4]: Hib vaccine is available from Aventis Pasteur. Hib vaccine orders from Wyeth require up to 60 days to fill and their supply is not likely to improve in 2002. Orders from Merck are taking 6 to 8 weeks to fill with lilttle improvement expected before December 2002.

Note [5]: MMR supply is sufficient to return to the routine schedule as recommended by the ACIP/AAP. However, additional vaccine is not available for ambitious recall or special initiative programs at this time.

Note[6]: PCV supplies are at critically low levels. Expect increased delays into last quarter of 2002.

Smallpox and Influenza Recommendations

The CDC's Advisory Committee on Immunization Practices (ACIP) issued recommendations June 20th on the administration of the smallpox and influenza vaccines. The details are as follows:

Smallpox

At this time, ACIP does not recommend vaccination of the general public as the potential benefits of the vaccine do not outweigh the risks of adverse events*. ACIP does recommend vaccination for specific teams pre-designated by the appropriate bioterrorism and public health authorities to be responsible for direct patient contact and investigation of the initial cases of smallpox.

The ACIP recommendations will now be sent to the CDC and then to U.S. Department of Health and Human Services (DHHS) Secretary Tommy Thompson for consideration.

The AAP Committee on Infectious Diseases has been drafting a smallpox policy statement that will be ready this fall. It is expected to closely reflect the ACIP recommendations.

The Academy has a number of bioterrorism resources available at: (http://www.aap.org/advocacy/releases/cad.htm), including a handout for parents titled, "Smallpox: Frequently Asked Questions." Additional information can be found at: (http://www.cdc.gov). For a rash illness assessment algorithm, poster copies are available from state health departments or they can be downloaded from (http://www.cdc.gov/nip/smallpox/poster-protocol.pdf). The CDC Interim Smallpox Response Plan and Guidelines can be found at: (http://www.bt.cdc.gov/DocumentsApp/Smallpox/RPG/index.asp).

Influenza

The Academy and ACIP are encouraging the use of flu vaccine in healthy children aged 6 to 23 months for the 2002-2003 influenza season. ACIP voted Thursday for the Vaccines for Children (VFC) program to provide flu vaccine for these children as well as their household contacts who are less than 18 years of age.

Children receiving the trivalent inactivated influenza vaccine for the first time who are younger than 9 years of age will need two doses. They should receive their first dose in October at the same time as those children who receive priority flu vaccination.

*[*Your editor has had the opportunity to observe first-hand the validity of this comment by CDC. In 1947, there was a case of smallpox in New York City (imported from Mexico), and there was felt to be a great need to re-vaccinate the public. As a resident pediatrician in a city hospital on the Lower East Side of Manhattan, I participated in vaccinating thousands of people, most of them adults who had been immigrants to the United States as much as thirty to forty years earlier, and who had had multiple vaccinations "on the way". The responses to new vaccination were of great magnitude; some of the adults had vaccinations as much as 2.5-3.0 cm. in diameter, accompanied by severe general symptoms. This, to us, was ample proof that cowpox vaccination against smallpox had not conferred permanent immunity; with present-day understanding, we would recognize that the milk-maids initially described had been receiving frequent booster doses.*

In the late 1950s-early 1960s, during the Greek revolution, there was a mass emigration from Greece and immigration to the United States. Greece did not require smallpox vaccination, but the United States did require it for entry, so that a lot of people received vaccination as they left their country. Many of the immigrants came to the area in which I worked, since there was a major Greek Orthodox Cathedral there. At this time, I was Attending Pediatrician at another city hospital. Prior to this event, we had anecdotally claimed that reactions to vaccination became dangerous after the age of seven. We knew this was true when we had to admit many of the immigrant children (seven and older) with severe reactions and in a number of cases with encephalitis caused by the cowpox vaccine. Outcomes were variable, and not always favorable.]

Karen Toker, M.D. FAAP
CATCH Co-Facilitator
Florida Regions I-IV

CATCH CORNER

CATCH activities continue on throughout the year with lectures to various groups about the meaning and importance of the medical home, and our CATCH projects continue to do good work throughout the State. Remember, however, although we often think of CATCH projects as only those which have been initially funded through a CATCH planning grant, that is really not the case. We have always included **all community projects which improve children's health as CATCH projects**. Although medical home development and access are CATCH's main focus, there are many other projects-literacy, daycare medical consultation, breast-feeding promotion projects, which are considered CATCH community projects. We have developed a CATCH section on the FCAAP web-site in which we are listing these projects with contact information. The goal of this web-site section is to share the work that the pediatricians in Florida are doing in their communities, and to provide contact information for people who might be trying to do the same kind of work in their own communities. **If any of you are doing community projects in your areas, please contact Deise Granado-Villar, MD or Karen Toker, MD so that we may add your work to the web-site. (see e-mail addresses below)**

Other news from CATCH:

1) In June, 2002, two Florida pediatricians received grants from the AAP Community Pediatrics Division under the **Reaching Out: Building Systems of Care** grant program. The two pediatricians were Arturo Brito,MD of Miami and Bethann Gemunder, MD of Tampa/St. Petersburg. These grants were for $10,000 each.
2) The deadline for the CATCH planning grant applications for 2002 has passed and we expect to have a good number of applications from Florida. These planning grants are generally given for new medical home projects but sometimes for other projects which increase children's access to new health initiatives. Of interest for next year is that, during the 2003 planning grant cycle, in addition to the usual CATCH planning grants, there will be a separate funding source for CATCH planning grants related to mental health, dental health, and immunization projects.

Also for next year, good news for those of you who find it hard to find funding for implementation of the project you planned with a CATCH planning grant. There will be a new set of CATCH implementation grants available starting in the 2003 application cycle in addition to the planning grants. These have been funded by the Hasbro Corporation and 6 grants will be funded per year for each of three years. The Hasbro Corporation has committed about $77,000 per year for these grants.

On a final note, please keep in mind that monies that we all contribute to the AAP Friends of Children Fund add to the numbers of grants that can be given out. If you do give to this Fund and desire that CATCH receive the monies that you donate, you **must designate CATCH as the recipient** both on your check and on the return form. If this designation is not checked, none of the money will go to CATCH.

Karen H. Toker ,MD
Karen_Toker@doh.state.fl.us
Deise Granado-Villar, MD
deise.granado-villar@mch.com ☐

Kudos...

...to Douglas J. Barrett, who has been appointed Vice President of Health Affairs at the University of Florida. He has relinquished his post as Chairman of the Department of Pediatrics.☐

Congratulations...

...to Terence Flotte, M.D., who has been appointed as Chairman of the Department of Pediatrics at the University of Florida. Dr. Flotte is a graduate of Louisiana State University, and did his residency and fellowship in pulmonary medicine at Johns Hopkins. He has been at the University of Florida since 1996 as

Director of the Gene Therapy Center.□

Our Speakers at the Annual Meeting, June 21-23, 2002

Lou Cooper's Keynote Address and Advocacy	Cliff Rapp, FPIC, The Perfect Storm	Jeff Brosco on Developmental Delays
Joan Meek speaks on breastfeeding	David Burchfield speaks on pain and sedation	Jonathan Schneider on Visual Diagnosis
David Skoner on Treatment of Asthma	Arno Zaritsky on Search for Evidence	Sharon Perlman discusses renal anomalies
Joseph Dohar on Otitis	Regino Gonzalez-Peralta on Hepatitis C	Juan Dumois on Encephalitis
David Granet on The Red Eye	Barrett on Top Ten	Stalvey on Hyperglycemia

glaxo smithkline ad

Breastfeeding directly related to lead release from bone

NEW YORK (Reuters Health) - Women who exclusively breastfeed their infants have higher blood lead levels than women who engage in mixed feeding practices or those who do not breastfeed, according to a recent report. The findings support the hypothesis that lactation stimulates lead release from bone to blood. Dr. Mauricio Hernández-Avila, from the Instituto Nacional de Salud Pública in Morelos, Mexico, and colleagues measured lead levels in blood and in bone, using K x-ray fluorescence, in 425 women following pregnancy. The women were also surveyed regarding their breastfeeding practices.

The average blood lead level at delivery was 8.4 micrograms/dL. After peaking at 1 month after delivery, blood lead levels decreased as the time from delivery increased. Furthermore, blood lead levels were directly related to bone lead levels, the authors note in the March 1st issue of the American Journal of Epidemiology.

After adjusting for bone lead level and environmental exposure, women who exclusively breastfed their infants had blood lead levels that were "0.4 and 1.4 micrograms/dL higher" than those of women who engaged in mixed feeding practices and women who had stopped lactation, respectively.

While the findings suggest that breastfeeding promotes lead release from bone, "the benefits of nursing clearly outweigh the risks" associated with lead exposure, the investigators emphasize. Furthermore, previous findings indicate that lead levels are actually higher in infant formula than in breast milk.

"Our data underscore the relevance of searching for and implementing procedures that reduce lead exposure from endogenous sources as well as environmental sources," the researchers conclude.

Am J Epidemiol 2002;155:420-428. ☐

DEET Insecticides

By THE ASSOCIATED PRESS

A study, according to a "report today" in The New England Journal of Medicine, has concluded that insect repellents containing the chemical DEET provide the best protection against mosquito bites.

Dr. Mark Fradin, a dermatologist, worked with Jonathan Day of the Florida Medical Entomology Laboratory in Vero Beach to test the effectiveness of 16 products. Each was tested three times on 15 workers at the University of Florida laboratory. Bug sprays and lotions that rely on plant oils or another chemicals do not last as long and might require several applications. Three wristband repellents that were tested did not work at all.

"...I don't think DEET is a perfect repellent," said Dr. Mark Fradin of Chapel Hill, N.C. "But it is still more effective and very safe."

The above information is an extract from an Article in today's New York Times. For complete information read the NYT or the full NEJ article. ☐

Lead Again

[FDA posts press releases and other notices of recalls from the firms involved as a service to consumers, the media, and other interested parties. FDA does not endorse either the product or the company.]

Nature's Way Products, Inc. Recalls Nettle
Because of Possible Health Risk

NEWS RELEASE
Contact: Nature's Way Products, Inc (1-800-283-3323)
For Immediate Release

Nature's Way Products, Inc. Recalls Nettle Because of Possible Health Risk
Springville, UT - June 28, 2002 -- Nature's Way Products, Inc. of Springville, UT is recalling four lots of its 100 count Nature's Way brand Nettle capsules because the product contains excessive amounts of lead. People, especially children, who consume high levels of lead, can suffer serious damage to their central nervous systems, sometimes leading to permanent neurological damage.

The affected lots of the product were distributed nationwide primarily in health food retail establishments between October 2001 and May 2002. The lot numbers affected by this recall are 131237, 131238, 140738 and 215229. Other lot numbers of the Nature's Way brand Nettle product are not affected and are not involved in this recall. The capsules are packaged in white 150cc plastic bottles with green lids under the Nature's Way brand label and can be identified by the lot number printed on the bottom of each bottle.

The problem has been traced to a single batch of raw material that was used to manufacture the four affected lots. Consumers who have purchased any of the affected lots of the product are urged to contact Nature's Way Products, Inc. at 1-800-283-3323 to return the product for a full refund.☐

(◂ Continued from page 9)

phase, and intravenous contrast (gadopentatate dimeglumine). The protocol was designed to help distinguish marrow from other pathologic tissue.

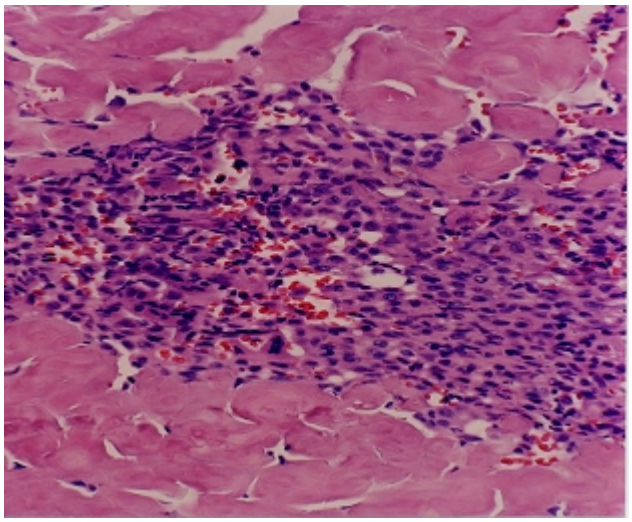

Figure 1. Low power view of hemangiopericytoma; osteoid material evident; prominent vascular clefts or spaces

TIO tumor RNA isolation and RT-PCR: Portions of the surgically resected lesions (100 mg) were disrupted with a rotor-stator homogenizer and total RNA was isolated from the tissues using the Qiagen RNeasy Mini Kit according to the manufacturer's instructions. RT-PCR was performed according to standard protocols with primers specific for human FGF-23 mRNA. The resulting products were electrophoresed on a 1.5% ethidium bromide stained agarose gel in parallel with a 100 bp DNA ladder.

Serum FGF-23 measurements: FGF-23 concentrations were determined using the Immutopics, Inc. FGF-23 serum assay. This assay isa two-site ELISA that recognizes the C-terminal portion of human FGF-23. A standard curve is generated using conditioned media from cells stably expressing human FGF-23, and serum concentrations are determined in Reference Units (RU)/ml. All serum samples were assayed in duplicate and the average value is presented.

Table II

Biochemical Parameters before and after Removal of Hemangiopericytoma of Left Iliac Wing

Time after surgery	Phosphorus (mg/dL)	Calcium (mg/dL)	Alkaline phos. (U/L)	25 vitamin D (ng/mL)	1,25 vitamin D (pg/mL)	PTH (pg/mL)	FGF-23 *(RU/mL)
Pre-operative	1.5	10.3	1044	14	28	69	
10 hrs	2.1	8.9					
24 hrs	2.1	9.1	729				161
48 hrs	2.6	9.0	755		49		43
8 days	3.1	9.6	801	13	104	161	
1 mo	4.7	8.6	723	10	162	103	
6 mos	5.2	9.6	452	22	131	52	

*RU = Reference units. Normal values in 30 adult control patients were 67.9±7.9 RU/mL

Results

Phosphorus levels were consistently low in our patient and his clinical condition responded poorly to supplementation with oral calcitriol and phosphate. MR gradient recall imaging clearly showed the lesion that was missed by conventional methods: plain X-ray, technetium bone scan, CT, and scout MR using inversion recovery. Removal of a hemangiopericytoma from the left iliac wing resulted in rapid recovery of serum phosphorus and 1,25- hydroxyvitamin D levels. FGF-23 mRNA was absent from the non-ossifying fibroma removed from the patient, a procedure which did not reverse his metabolic abnormalities. FGF-23 rnRNA was present in the hemangiopericytoma removed from the left iliac wing, following which serum phosphate and calcitriol levels rose. Serum FGF-23 concentrations were markedly elevated preoperatively and decreased by 91% at 24 hours and 99% at 48 hours after the tumor was removed.

Conclusions

MR gradient recall sequencing may highlight bone tumors associated with TIO that are not identifiable by more conventional means.

Our patient provides further evidence that FGF-23 is present in tumors causing TIO; to our knowledge, he is the first pediatric patient in whom this has been documented.

Serum FGF-23 is elevated in TIO and declines dramatically 24 hours after tumor removal. Within 48 hours hypophosphatemia and reduced 1,25- hydroxyvitamin levels begin to normalize, linking FGF-23 with these metabolic derangements.

Serum measurements of FGF-23 may prove useful in the initial diagnosis of TIO, in documenting that the responsible tumor has been completely removed, or in monitoring for recurrence of tumors that carry such a risk.

References

Shimada T, Mizutani S, Muto T, et al. Cloning and characterization of FGF23 as a causative factor of tumor-induced osteomalacia. 2001; Proc Ntl Acad Sci USA, 98:6500-6505

Quarles LD, Drezner MK. Pathophysiology of X-linked hypophosphatemia, tumor-induced osteomalacia, and autosomal dominant hypophosphatemia: a per PHEXing problem. 2001; J Clin Endocrinol Metab 86:494-496

Drezner MK. Tumor induced osteomalacia. 2001; Rev Endocr Metab Disord, 2: 175-186□

Legislative

(◂ continued from page 10)

technology dependent children from birth through age 21. The report must identify the number of such children who could, if appropriate transitional services were available, return home or move to a less institutional setting. The agency will establish minimum staffing standards and quality requirements for a subacute pediatric transitional care center to be operated as a two year pilot program in Miami-Dade County.

All duties, funds and personnel relating to consumer complaints, investigations and prosecutorial services for the Division of Medical Quality Assurance, councils and boards, are transferred to the Department of Health from the Agency for Health Care Administration (AHCA). Authority to contract with AHCA for such services is terminated effective June 30, 2002. Authorization to contract with the Department of Legal Affairs for the investigative and prosecutorial services is provided, but not required.

Section 456.047, F.S., relating to standardized credentialing for certain health care practitioners is repealed.

CS/CS/HB 817 - Newborn Infant Screening

(Chapter No. 2002-69) Effective Date: April 22, 2002

A fifteen member Infant Screening Programs Task Force is created within the Division of Children's Medical Services of the Department of Health to conduct comparative research regarding the infant screening programs currently operating in other states in order to make recommendations regarding Florida's newborn infant screening program. A plan tailored to the needs of Florida's population is to be developed. Research is to be completed by August 1, 2002. The plan and recommendations must be submitted to the Secretary of the Department of Health, the Governor and the Legislature by September 1, 2002.

SB 46E - Health Care / Health Flex Plans

(Chapter No. 2002-389) Effective Date: July 1, and October 1, 2002

Revisions to the prompt payment of health insurance claims law are contained in this legislation. Revisions standardize all time periods for insurers and HMO's to pay, deny, or contest any claim, or portion of a claim (20 days for electronic claims and 40 days for nonelectronic claims). Failure to pay or deny a claim within 120 days for electronic or 140 days for nonelectronic claims creates an "uncontestable obligation" for the insurer or HMO to pay the claim. Separate time frames are established for submittal of claims to a primary and secondary insurer or HMO. Time frames are also established for overpayment claims by insurers and HMOs and the interest rate for overdue payments of claims is raised to 12 percent a year. The prompt pay provisions may not be waived, voided or nullified by contract. Sanctions are provided for health plans which fail to comply with the time frames and the Agency for Health Care Administration is required to determine if there is a "pattern of noncompliance" by health plans or providers as to claims payments. Findings are to be reported to licensure or certification entities. HMO's and insurers are deemed responsible for compliance with the law when contracting for services through a health care risk contract.

This legislation creates a pilot program to provide health care coverage (health flex plans) to uninsured persons who have a family income equal to or less than 200 percent of the federal poverty level. These plans would be exempt from the requirements of the Florida Insurance Code including licensing and are authorized to limit or exclude mandated benefits; cap the total amount of claims paid per year per enrollee; and/or limit the number of enrollees. For purposes of prohibiting unfair trade practices the plans are subject to applicable provisions of the Unfair Trade Practices statute contained in Chapter 626, Florida Statutes.

The Agency for Health Care Administration (AHCA) must develop guidelines for reviewing plan applications and must disapprove or withdraw approval of plans that do not meet minimum standards for quality of care and access to care. The Department of Insurance (DOI) will develop guidelines for reviewing plans to insure that plans do not contain any ambiguous, inconsistent or misleading provisions; provide benefits that are unreasonable in relation to the premium charged; or, cannot demonstrate that the plan is financially sound.

Eligibility to enroll in the plans is limited to residents of the state who are 64 years of age or younger with an income equal to or less that 200% of the federal poverty level and are not covered by or have been covered in the last six months by private insurance or are eligible for Medicaid, Medicare or Kidcare.

The pilot program may be established in three areas of the state with the highest levels of uninsured persons and in Indian River County. AHCA and DOI must submit an evaluation of the program and the plans by January 1, 2004 to the Governor, President of the Senate and Speaker of the House of Representatives. The Health Flex Plan statute expires on July 1, 2004 and must be reenacted to continue beyond that date.

The small group insurance law has been amended to allow the rating of one person groups to be separated from groups of 2 to 50 employees. Premiums will be allowed to rise to 125% of the rate for the 2 to 50 group the first year and to 150% the second year. Small group plans will be exempt from any law restricting or limiting deductibles, co-insurance, co-payments, or annual or lifetime maximum benefits unless it is made expressly applicable to these policies or plans.

The requirement for an HMO to determine that a subscriber requires examination by an ophthalmologist, in additional to the primary care physician, is deleted for contractually covered services of a contracted ophthalmologist.

CS/SB 1262 - Department of Health / Bioterrorism

(Chapter No. 2002-269) Effective Date: May 23, 2002

This legislation provides additional powers to the Department of Health during defined public health emergencies from infectious disease, chemical agents, nuclear agents, biological toxins or situations involving mass casualties or natural disasters. The State Health Officer is required to consult with the Governor and to notify the Chief of Domestic Security Initiatives before declaring a public health emergency.

The State Health Officer is authorized to take specified actions to protect the public health including reactivating the licenses of certain health practitioners to provide services during a public health emergency and instituting mandatory quarantine.

Immunity from civil liability under the Good Samaritan Act is extended to persons who gratuitously and in good faith render emergency care or treatment in direct response to a public health emergency. This immunity is also extended to any licensed hospital, any employee providing patient care in a clinical area and any person licensed to practice medicine who in good faith renders medical care necessitated by a declared public health emergency.

CS/SB 2048 - Jennifer Knight Medicaid Lung Transplant Act

(Chapter No. 2002-35) Effective Date: July 1, 2002

The Agency for Health Care Administration is required to include within the Medicaid program payment for medially necessary lung transplant services for recipients. This expansion is subject to the availability of funds and subject to any limitations or directions provided in the General Appropriations Act or ch. 216, Florida Statutes. Adult lung transplants are exempt from the county contribution requirement for inpatient hospitalization.□

AAP

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red reflex examination or examination by an ophthalmologist experienced in the examination and treatment of the eyes of young infants, as described previously (3b).

3) Infants with a history of leukokoria (a white pupillary reflex) in 1 or both eyes noted by parents or other observers or on any physical examination, and those with absence of a red reflex should have an examination by an ophthalmologist experienced in the examination and treatment of the eyes of young infants, as described previously (3b).

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James B. Ruben, MD
CONSULTANT
Michael Redmond, MD
STAFF
Stephanie M. Mucha, MPH
*Lead author

REFERENCES

1. American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine and Section on Ophthalmology. Eye examination and vision screening in infants, children, and young adults. Pediatrics. 1996;98:153-157
2. Ogut MS, Bozkurt N, Ozek E, Birgen H, Kazokoglu H, Ogut M. Effects and side effects of mydriatic eyedrops in neonates. Eur J Ophthalmol. 1996;6:192-196
3. Fraunfelder FT. Pupil dilation using phenylephrine alone or in combination with tropicamide. Ophthalmology. 1999;106:4
4. Gaynes BI. Monitoring drug safety; cardiac events in routine mydriasis. Optom Vis Sci. 1998;75:245-246
5. Resano A, Esteve C, Fernandex Benitez M. Allergic contact blepharoconjunctivitis due to phenylephrine eye drops. J Investig Allergol Clin Immunol. 1999;9:55-57
6. Boukhman MP, Maibach HI. Allergic contact dermatitis from tropicamide ophthalmic solution. Contact Dermatitis. 1999;41:47-48

aPassed in California and under consideration in New York, Massachusetts, South Carolina, Florida, and New Jersey (at the time of publication).

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time. ☐

AAP NATIONAL CONFERENCE AND EXHIBITION
(Formerly AAP Annual Meeting)

2002	Boston, MA	October 19-23
2003	New Orleans, LA	November 1-5☐

Chairmen

(◂ continued from page 7)

program is a unique function started and maintained by our students. Students in this program go to underprivileged communities to interest children in pursuing careers in the health care profession. The "DOctor's Bag" program has been nationally recognized and noted in many national publications. Many students from our college participate in the overseas medical programs that were developed with the public health school to provide medical care in Guatemala and Jamaica.

Post-graduate training in pediatrics is an important part of the mission of the department of pediatrics. Our University sponsors several post-graduate residencies many of which are in family practice. The department of pediatrics plays a direct role in developing the pediatric educational curriculum for many of these training programs. Several of the family practice residents rotate through the pediatrics clinic on our Davie campus so they may increase their experience in pediatric ambulatory care. Nova Southeastern University cosponsors a pediatric residency at Miami Children's Hospital. This is the only pediatric residency in the state of Florida that is accredited by both the AOA and the ACGME.

Having completed my first year in Florida, I now set my sights on the future of our department. More cooperative programs with other schools on the Nova Southeastern University campus are to be developed. Relationships with our schools of speech and audiology and education are a natural next step. We will pursue other opportunities to do research in areas of primary care pediatrics and explore more ways to involve our students and residents in these projects. I am eager to develop more dually accredited (AOA/ACGME) residencies in the state of Florida to provide our students with a greater opportunity to pursue pediatrics as a career.

Kudos...

...to Edward E. Packer, D.O., FAAP, FACOP, who has assumed the chairmanship of the Department of Pediatrics at Nova Southeastern University College of Osteopathic Medicine. Dr. Packer received his B.A. degree in 1971 and D.O. in 1976. He served an internship at the J.F.Kennedy Memorial Hospital in Stratford, N.J. and residency at the Thomas Jefferson University Hospital in Philadelphia, and spent 21 years in Arizona before coming to Florida last year.☐

School

(◂ continued from page 11)

members to work on various timely school health issues. I wanted to write this column to:

1. Urge those of you who are involved to share with the committee on School Health your experience, activities, or projects. These will be reported in the Florida Pediatrician and/ or the AAP School Health newsletter. [Letters to the Editor!]
2. Urge each and every one of you to feel free to send any school health issues you like the committee to work on.
3. Urge those of you who are interested in serving on the Committee on School Health to contact me via fax or E-Mail with your area of interest.

For any support I can provide, please do not hesitate to contact me.

"Healthier children, school environments, home, and community translate into healthier future".

References:

1. American Academy of Pediatrics. School Health Policy and Practice. Elk Grove Village, IL. 1993
2. American Academy of Pediatrics. School Health Train the Trainer. http://www.schoolhealth.org/trnthtrn/section1/sect1a.html
3. Barnett S, Duncan P, and O'Connor KG. Pediatricians' Response to the Demand for School Health Programming. *Pediatrics.*1999; 103(4): e45. □

President

(◂ continued from page 3)

Again, I congratulate all of you. I hope you had a restful summer and I look forward to working with you during this last year of my Presidency. As always, I appreciate the opportunity to serve as your President.
Sincerely,
Richard L. Bucciarelli, M.D.
President, Florida Chapter
American Academy of Pediatrics□

Congratulations...

...to **Carden Johnson, M.D.**, of Birmingham, AL, who has just been chosen as President-Elect of the American Academy of Pediatrics, to assume the presidency in 2003.

A Little History

[I wish I knew the origin of this little tale. I would like to attribute it to someone. However, it came to me the way many things do: via e-mail, and here it is]

His name was Fleming, and he was a poor Scottish farmer. One day, while trying to make a living for his family, he heard a cry for help coming from a nearby bog. He dropped his tools and ran to the bog. There, mired to his waist in black muck, was a terrified boy, screaming and struggling to free himself. Farmer Fleming saved the lad from what could have abeen a slow and terrifying death.

The next day, a fancy carriage pulled up to the Scotsman's sparse surroundings. An elegantly dressed nobleman stepped out and introduced himself as the father of the boy Farmer Fleming had saved. "I want to repay you," said the nobleman. "You saved my son's life." "No, I can't accept payment for what I did," the Scottish farmer replied, waving off the offer. At that moment, the farmer's own son came to the door of the family hovel. "Is that your son?" the nobleman asked. "Yes", the farmer replied proudly. "I'll make you a deal. Let me provide him with the level of education my son will enjoy. If the lad is anything like his father, he'll no doubt grow to be a man we both will be proud of." And that he did.

Farmer Fleming's son attended the very best schools and in time he was graduated from St. Mary's Hospital Medical School in London, and went on to become known throughout the world as the noted Sir Alexander Fleming, the discoverer of Penicillin.

Years afterward, the same nobleman's son who was saved from the bog was stricken with pneumonia. What saved his life this time? Penicillin. The name of the nobleman? Lord Randolph Churchill. His son's name? Sir Winston Churchill.

Someone once said: What goes around, comes around.□

Upcoming Continuing Medical Education Events

THE FLORIDA PEDIATRICIAN will publish Upcoming Continuing Medical Education Events planned. Please send notices to the Editor as early as possible, in order to accommodate press times in February, May, August, and November.

Program: Practical Pediatrics
Dates: August 30 - September 1, 2002
Place: Québec City, Québec, Canada
Credit: Hour for hour credit for Category 1 for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics and Canadian Paediatric Society
Inquiries: American Academy of Pediatrics, (800)433-9016, ext 6796 or 7657

Program: Practical Pediatrics
Dates: October 3 - 6, 2002
Place: Portland, Oregon
Credit: Hour for hour credit for Category 1 for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: American Academy of Pediatrics, (800)433-9016, ext 6796 or 7657

Program: Practical Pediatrics
Dates: November 8 - 10, 2002
Place: Amelia Island, Florida
Credit: Hour for hour credit for Category 1 for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: American Academy of Pediatrics, (800)433-9016, ext 6796 or 7657

Program: Joe DiMaggio Children's Hospital 13th Annual Pediatric Symposium
Dates: November 9 - 10, 2002
Place: Embassy Suites Hotel, Ft. Lauderdale, FL
Credit: Up to 11 hours for Category 1 for AMA Physician Recognition Award
Sponsor: Joe DiMaggio Children's Hospital
Inquiries: Denise Causa, (954) 985-5837 or dcausa@mhs.net

Program: Neonatal Hematology and Immunology
Dates: November 14 - 16, 2002
Place: Coronado Springs Resort, Lake Buena Vista FL
Credit: Up to 15 hours for Category 1 for AMA Physician Recognition Award
Sponsor: University of South Florida and All Children's Hospital
Inquiries: Office of Continuing Professional Education (813)974-4296 or (800) 852-5362 or hmoretti@hsc.usf.edu

Program: Practical Pediatrics
Dates: December 13 - 15, 2002
Place: Williamsburg, Virginia
Credit: Hour for hour for Category 1 for AMA Physician Recognition Award
Sponsor: American Academy of Pediatrics
Inquiries: American Academy of Pediatrics, (800)433-9016, ext 6796 or 7657

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