# NEWS

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los angeles pediatric society


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## FROM THE PRESIDENT

**Mark Powell, MD**

### Lessons Learned from Election 2008

How history books will ultimately chronicle the election of 2008 is something that will provide fodder for political pundits for many months to come. However, one thing can be said with certainty: never before have we seen such enthusiastic participation. People from all walks of life suddenly felt it imperative that their voices be heard. Whether their motivation was to maintain the status quo or to implement radical change, the majority of the population was no longer content to sit on the sidelines and hope they would be represented. They educated themselves, chose a strategy for promoting their cause, then took to the streets. Suddenly, people refused to be silenced. Adages like "It has to be done this way" were no longer tolerated. People not only asked for change, they demanded it and were willing to put muscle behind their cause and push for it. The energy was palpable. Some might even say it was electrifying. The end result was determined not only by the ballot count, but by how empowered people felt. To a greater degree than ever before, people were on their feet and were participating.

I think there are a few important lessons here; our opinions count, involvement is empowering, unacceptable situations need not be tolerated, and change is possible. Imagine what the practice of pediatrics could become if each of us took this lesson more greatly to heart? We would not only be better advocates for children but we would be better advocates for ourselves. Pediatrics has traditionally been assigned the backseat in health care. And by whose dictum? If this election has taught us nothing else, perhaps it has made us believe that we can designate ourselves to be the drivers.

What might happen if we continue to be relegated to sit in the back of the bus? To begin with, there are influences working their way into societal prominence that could threaten the very existence of pediatrics as a specialty. Many insurance companies are advocating for retail based clinics that are staffed by nurse practitioners and that could poten-

*Continued on page 2*

## INSIDE

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An Independent Nonprofit Organization
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**From the President**
**Continued from page 1**

tially usurp the role of the pediatrician's office. Patients would not only utilize these clinics to receive immunizations but would also access them for urgent care. Administration of these clinics would represent significant savings to insurance companies, but at what cost to the patient? Retail based clinics would be promoted under the façade of providing equivalent care for a better price. Ultimately, the hours we spent in medical school and in residency to develop a real expertise in the care and management of patients would be reduced to a luxury enjoyed only by patients who feel entitled to selfish indulgences.

> "Some people make things happen."
> "Some people watch things happen."
> "Some people wonder what happened."

Meanwhile, insurance companies continue to generate huge profits in premiums while simultaneously paying out lesser amounts to subsidize these clinics. As pediatricians, are we going to sit back and passively allow our profession to be reduced to a Walmart red tag special?

Even if we succeed in resisting the pressures to be denigrated to a mini-mall, can the practice of pediatrics remain fiscally viable? I'm saddened when I read about the circumstances under which some doctors are trying to survive. Many have ceased giving some recommended vaccines because the amount they are reimbursed by some insurance plans is simply too far below their cost to make providing them financially possible. In many instances, not only is the contracted rate of reimbursement arbitrary, but we are bullied into believing that we have to accept the terms of these contracts unconditionally. We are made to feel that the lives of our patients are the property of the insurance companies and if we want to continue to have the privilege of caring for our patients, we have to do so by complying with the insurance company's rules. To wit: Take this paltry reimbursement and be happy with it.

This problem is compounded by the fact that as pediatricians we tend to be non-oppositional, nice people. We are committed to doing what's right for our patients almost regardless of cost. The largest perversion here is that pediatricians believe they are giving their services to the patient, when in fact they are giving them away to the insurance companies as the actual costs of providing services are calculated into the premiums families pay. The low rate of reimbursement actually augments insurance company's profits.

This phenomenon not only impacts our individual practices, it also impacts the future of pediatrics. As reimbursements continue to decline, fewer and fewer medical school graduates are even considering choosing pediatrics as their specialty. "The proportion of U.S. medical school graduates entering the primary care specialties dropped from 50% in 1998 to 38% in 2006 and of those, the smallest portion chose pediatrics. Decreasing job satisfaction, the increase in educational debt (which now routinely exceeds $100,000.00) and the growing disparity in salary relative to other specialties has created a strong sense that becoming a primary care physician may be a fool's errand. Thirty minutes performing a diagnostic, surgical, or imaging procedure often pays three times as much as a 30 minute visit with a patient who has complicated medical condition."[1]

The September 10, 2008 edition of USA Today reported that the average salary for radiologists was $350,000 per year. The same report put pediatricians at the very bottom of the list at an average salary of $125,000. Interestingly, nurse anesthetists were reported to be making $185,000.

"Some people make things happen."

"Some people watch things happen."

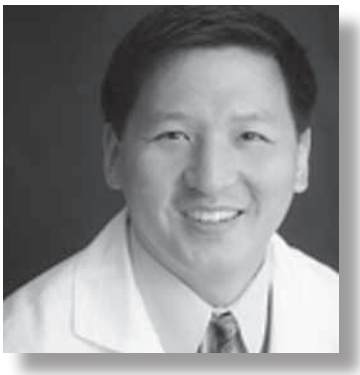
"Some people wonder what happened."

We can either be in the last category to our detriment and to the impending demise of primary care pediatrics as a viable specialty or we can learn from the lessons of the 2008 election and begin to make a push for change. Let's renew our commitment and enthusiasm for our profession and let our voices be heard. This is a call to charge, a call to stand together and a call to refuse to be made to feel inconsequential. We are pediatricians and we make important contributions to the well being of our patients. We should not tolerate our profession or our patients to be consigned to the lowest rung on the ladder. Children are the future of any society and their care should not be an after thought or given no thought at all. Let's energize our base, let's stand on our principals, and let's move our cause forward. Can we do it? Yes we can!

**Reference**

1. Primary care—the best job in medicine? Woo, B., NEJM 355;9 8/31/06, p 864

## ROBOTIC SURGERY IN CHILDREN FOR PEDIATRIC UROLOGY CONDITIONS



**Chester J. Koh, MD, FAAP**

**Division of Pediatric Urology, Director, Robotic Surgery Program at Childrens Hospital Los Angeles, Childrens Hospital Los Angeles / USC Keck School of Medicine**

In the February 2008 issue of the Los Angeles Pediatric Society (LAPS) newsletter, Mark Powell, MD noted the society's educational mission of keeping its members abreast of the latest medical advances that will benefit our pediatric patients. This article hopefully serves as one of the many examples that the society employs to help pediatricians deliver high quality pediatric care to their patients.

Minimally invasive surgery in children in the field of pediatric urology began in the mid-1970s where laparoscopy was used for the diagnosis of cryptorchidism (undescended testes). Since then, laparoscopic surgery has become a mainstay in the diagnosis and treatment of pediatric urologic conditions. Laparoscopic surgery has been shown to be a safe and effective modality of treatment, especially for ablative procedures such as nephrectomy and adrenalectomy. However, for reconstructive procedures such as pyeloplasty and ureteral reimplantation, only a modest adoption by the pediatric urology field has limited the availability of minimally invasive surgery to pediatric urology patients, with one key reason being the inefficiencies of laparoscopic suturing required for most reconstructive procedures.

Robotic surgery using the Da Vinci Surgical robot (Intuitive Surgical, Sunnyvale, CA) represents the next generation of laparoscopic surgery for pediatric urology, and is on course to revolutionize pediatric urologic surgery as it has done for adult urologic surgery (robotic prostatectomies for prostate cancer). Since FDA approval was granted in 2000, the Da Vinci surgical robot has enabled a minimally invasive option to children for their pediatric urology needs due to its three-dimensional and magnified visualization, intuitive computer-enhanced motion control, and its fully articulating "Endowrist" instruments.

Essentially, the Da Vinci robot allows more reconstructive procedures to be performed in a minimally invasive fashion, where the experienced surgeon can mimic open surgical movements and technique with the robotic arms. As a result, robotic surgery represents the latest advances in minimally invasive surgery for children, and the advantages include:

1. Smaller incisions with improved post-op cosmesis
2. Better visualization and instrument control during surgery, which should lead to safer procedures and better outcomes for the pediatric patient.
3. Shorter hospital stays
4. Decreased postoperative pain medication requirements

Robotic pyeloplasty for ureteropelvic junction obstruction and robotic ureteral reimplantation for vesicoureteral reflux are the most common pediatric urology procedures for which the Da Vinci robot is currently being used. Other uses include robotic ureteroureterostomy, Mitrofanoff continent urinary diversion, and bladder augmentation. Essentially most reconstructive procedures that require suturing can be performed with the Da Vinci robot as a minimally invasive option; however this decision should be an informed decision between the patient's family (and the patient if appropriate) and the treating surgeon.

Robotic surgery in children has been used in other pediatric surgical specialties, including pediatric surgery, pediatric cardiac surgery, pediatric gynecology, and pediatric kidney transplantation (donor nephrectomy).

Minimally invasive surgery for pediatric urology conditions continues to evolve, and robotic surgery has made this option available for children who require reconstructive surgery for their pediatric urology conditions. I encourage both parents and pediatricians to explore the option of minimally invasive robotic surgery when reconstructive surgery has been recommended. More information about our division can be found at www.PediatricUrologyLA.com and at www.CHLA.org.

## BRENNEMANN PREVIEW 2009

Since sixty six follows sixty five, the Los Angeles Pediatric Society (LAPS) is looking forward to celebrating the sixty sixth edition of the Brennemann Lectures at the Disney's Paradise Pier Hotel. Save October 22nd through the 25th, 2009. The lectures actually begin on Friday morning the 23rd. I'm pleased to announce we have secured the commitments of four outstanding authorities. Vincent J. Wang, M.D. (Division of Emergency Medicine, Childrens Hospital of Los Angeles) will address the field of pediatric emergency medicine. Dr. Wang is an enthusiastic and outstanding speaker. David Ferry, M.D. (Cedars-Sinai, UCLA) will address pressing issues in cardiology. An old friend and a terrific speaker, Wilbert (Bill) Mason, M.D. (Childrens Hospital, Los Angeles ) will bring us up to speed on infectious diseases. The important subject of Pediatric Urology will be discussed by Chester Koh, MD. Dr. Koh is a member of the Division of Pediatric Urology at Childrens Hospital of Los Angeles and represents the cutting edge in new developments in his field of interest.

The Clifford Rubin Lectureship should also serve as an outstanding attraction. Needless to say, the Disneyland Park and California Adventure Land Park offer boundless entertainment for attendees and their families. I urge you to attend what should be an educational and entertainment treat. More to follow and see you at "The Magic Kingdom."

*Marshall G. Goldberg, MD, FAAP, FAAAA&I, LAPS Program Chairman*

# DISASTER PREPAREDNESS—BLAST INJURIES

**Paula J. Whiteman, MD, FAAP, FACEP**

Fortunately, blast injuries are rare in the United States. Nevertheless, we must be prepared for the unexpected. Many physicians, including pediatricians, are asked to be on standby by their hospitals in the case of emergency.

Aside from terrorism, industrial explosions or natural gas accumulation in a building can produce pressure waves approaching that of a bomb blast. First, the basic facts should be determined, such as the timing and size of the event, how close the victims were to blast, whether the victims were thrown by the force. In addition to the blast itself, there are other considerations such as whether there are any resultant fires, smoke, debris, chemical or radioactive contamination, as may occur in a 'dirty' bomb. EMS may need to activate disaster or hazardous material responses. In a large blast, there may also be collapsed buildings which must be searched for survivors.

The victim's proximity is important because the intensity of the explosion declines with the cubed root of the distance. Thus, a patient who is 10 feet from the explosive site received 9 times as much force as someone 20 feet away. Blast waves are also reflected off solid structures, such as walls, which can compound the injuries.

The chaos created by a large blast, be it a bomb or a natural gas explosion, is similar to that of a combat zone. The resulting trauma tends to be multisystem, life-threatening injuries potentially involving many victims simultaneously and may overwhelm the EMS system.

Blasts injuries tend to be triaged "upside-down". Meaning the less acutely injured patients tend to arrive first to the hospital, either by ambulance or personal conveyance. The more severely injured patients may outwardly appear relatively unscathed and tend to arrive later.

There may be radioactive contamination which can be screened for with a hand-held Geiger counter. If found, then decontamination will be required and the receiving hospital should be notified.

The initial injury is from the blast wave itself due to the impact of an over-pressure wave which travels through the body, especially affecting the gas-filled structures such as the lung, GI tract and middle ear. This is referred to as the primary injury. The barotrauma to the lung can cause a pnuemothorax, air embolism, or pulmonary contusion. The patients may present with wheezing or a cough. Patients can have inner ear damage and rupture the tympanic membrane. GI trauma can manifest as abdominal hemorrhage or perforation.

More easily detected secondary injuries result from flying debris which can penetrate or cause blunt force trauma.

Next, the victims can be thrown from the force of the blast resulting in fractures, amputations, and brain injuries. This tertiary injury pattern is a hallmark of high-energy explosives.

Lastly, there are the quaternary injuries which can be from exacerbations or complications from existing medical conditions or any other miscellaneous things. For example, smoke, dust or toxic fumes can cause breathing difficulty in patients with underlying asthma or COPD. Angina or myocardial infarction can result in those with coronary artery disease. In addition, there can be crush injuries from the collapse of structures or burns from resultant fires. All four categories of injury can be equally lethal.

A major source of preventable death can occur from exsanguination or significant extremity trauma. External hemorrhage should be controlled and may require using tourniquets in a mass casualty event. Fluids should be administered carefully, since volume overload can worsen pulmonary function.

Oxygen should be administered to all patients with respiratory symptoms and remember to prevent hypothermia by reducing heat loss.

It is important to remember that the most critically injured patient may be walking around on scene without external wounds. They may then present to your office for evaluation. Thus, it is important to be aware of the potential for occult injury.

## LAPS Membership Dues Notice

All dues notices for 2008 have been mailed out, either through email or USPS. Thank you to all LAPS members who have paid their dues and/or made a donation. If you have not yet remitted your dues, LAPS would appreciate your prompt payment.

You may pay your dues and/or make a donation by check and mail to: LAPS, PO Box 4198, Torrance CA 90510-4198

You may now also pay your dues and/or make a donation with a credit card through our website www.lapedsoc.org
If you have not received a notice, please contact us:
email at: eseaman@lapedsoc.org
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## Welcome New LAPS Members

Chester J. Koh, MD, FAAP, Pasadena
Margaret Eyler Legault, MD, San Gabriel
Jenna Christine Roberts, MD, Santa Monica
Sarah E.C. Salamon, MD, Pasadena

## Life Members

Danelle M. Fisher, MD, FAAP, Los Angeles
Daniel Lau, MD, FAAP, Los Angeles
Edward G. Mack, MD, Los Angeles
Asha Challu Saraf, MD, FAAP, Pasadena
Sloane Hope Sevran, MD, FAAP, Encino
Tracy Zaslow, MD, FAAP, Encino

# 2008 EVE AND GENE BLACK SUMMER MEDICAL CAREER PROGRAM

## White Memorial Medical Center

There are no words to describe my experiences at White Memorial Hospital. This experience has been one of the best things that has happened to me in my life, after all not every 17 year old gets the opportunity to see a heart beating, a foot surgery, a life being saved or a baby born everyday.

*Xochitla Davila*

## Olive View

The internship was one of the most exciting and moving experiences that I have ever taken part of. … Not only was I able to observe how these professional went about doing their jobs, but also learn the feelings and emotions each professional felt in doing them.

*Monica S. Moncada*

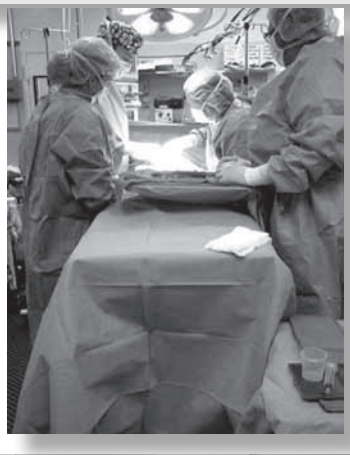
Being part of this program meant more to me than what most can imagine. It was more than an exploration for me… I learned more about myself within that month than what I thought I knew about "me" within my lifetime.

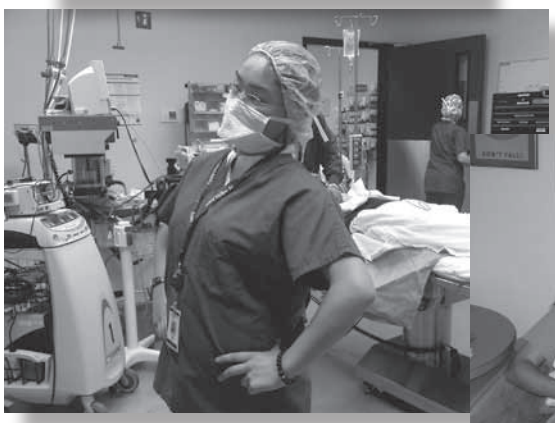
*Yadira Perez*

## LAC/USC

The reason I applied for this program was because I was uncertain if I wanted to be a doctor, but with this program I know that in eleven years or so I'll be a pediatrician.

*Jacqueline Mendoza*





## UCLA

On one occasion while shadowing a physical therapist in the Neonatal Intensive Care Unit, I was allowed to touch one of the premature infants, Isaac, a boy born at twenty three weeks into the pregnancy. … As little Isaac looked into my eyes, I realized that I wanted to make a difference in this child's life. He was so helpless, and as a medical doctor, I would have something to offer him.

*Daniel Yu*

## St. Johns/Santa Monica Hospital

It was an unbelievably remarkable experience to see the birth of a child as well as the operation. I am truly grateful I had this opportunity through the Gene Black program.

*Bryson Lochte*

## UCLA

There is a clarity that comes to being a doctor that I have been lucky enough in this month to learn. Doctors have the chance to give life again.

*Molly Evans*

Thank you to the participating hospitals, their counselors and all those that generously donated to support the 2008 Summer Medical Career Program—it is a life changing experience for those students involved!

For information on the **2009 Eve and Gene Black Summer Medical Career Program**, including FAQs, visit www.lapedsoc.org.

the los angeles pediatric society
Annual Spring Meeting and Parmelee Lecture

The Los Angeles Pediatric Society presents the

**ANNUAL SPRING MEETING AND PARMELEE LECTURE**

**Cyber Checkup 2.0: What Digital Footprints Tell Us about Kids' Health**

Speaker: Bobbie Eisenstock, PhD

**Thursday May 14, 2009**
**6:00 pm - 9:30 pm**

Place: Castaway Restaurant
Verdugo Room
1250 Harvard Rd
Burbank, CA 91501
Phone: 818-843-5013

This is an approved program of continuing medical education for two CME hours

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## Cyber Checkup 2.0

With every mouse-click, kids leave a digital footprint of their cyber identity. Digital footprints are new health indicators of children's and adolescents' well-being online that can reveal their susceptibility to offline risks for tobacco, alcohol or illicit drug use, sexual activity, eating disorders, suicide, bullying, sexual predators, and identity theft. Participants will learn about the dynamics of navigating the cyber culture and parental challenges of raising kids who are growing up online.

## Speaker

**BOBBIE EISENSTOCK, PhD** Assistant Professor at California State University Northridge and Media Education Consultant Dr. Eisenstock specializes in the social and psychological effects of new interactive media on children, teens and families. As an educator and consultant, she uses media literacy to promote healthy child and adolescent development. Among the groups with whom she has worked are Kaiser Family Foundation, American Academy of Pediatrics, Cedars-Sinai Pediatric Residency Program, Children's Hospital of Orange County, Planned Parenthood, National Youth Anti-Drug Media Campaign, National PTA, and Academy of Television Arts & Sciences. Her recent publications include Cyber Harm, a brochure for Teen Line at Cedars-Sinai Medical Center.

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**The Los Angeles Pediatric Society ANNUAL SPRING MEETING AND PARMELEE LECTURE**
**Thursday, May 14, 2009 Castaway Restaurant, Burbank, CA**

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**Advanced registration is required. Late Fee after May 6, 2009: Add $20 to each category**

| **BANQUET AND LECTURE:** | | | **LECTURE ONLY** | |
|---|---|---|---|---|
| Physician, Member of LAPS | $65 | $_____ | $20 | $ _____ |
| Emeritus Member of LAPS | $45 | $_____ | $20 | $ _____ |
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**Dinner:** ❑ Vegetarian ❑ Chicken

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**At the completion of these presentations the attendee will:**

1. Gain insight into kids' online activities and parental monitoring practices.
2. Understand cyber benefits and risks and be able to educate patients about about advantages and disadvantages and potential real life consequences.
3. Use AAP media history form as a springboard to assess family Internet habits.
4. Become familiar with media literacy strategies as a practical approach to empower children and adolescents on the cyber playground.
5. Identify age-appropriate resources to recommend about safe and responsible web surfing.
6. Increase awareness of opportunities for pediatrician media advocacy to improve child health in the Digital Age.

**ACCREDITATION:** The Los Angeles Pediatric Society is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians. The Los Angeles Pediatric Society takes responsibility for the content, quality and scientific integrity of this CME activity. The Los Angeles Pediatric Society designates this educational activity for a maximum of *2 AMA PRA Category 1 Credit(s)™*. Physicians should only claim credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification Medical Education.

# THE DIGITAL DILEMMA—Advice for Parents about Their Children and the Internet

**Johanna Olson, MD, Vice President**

The mother of an eleven year old girl comes into your office and asks you what she should do about her child spending 4-5 hours a night in her room, on her computer. Mom states she has never seemed happier than she has been since she got her new laptop for her birthday. What should you tell her?

Mom then asks if she should be concerned about online sexual predators. Should she let her instant message? Should she be allowed to have her own Myspace page? What about cyber-bullying? Should she be concerned that she has ten or more conversations going on at once? Is there anything beneficial about her daughter being online?

Cyber-bullying, online social networking, instant messaging, World of Warcraft, emoticons, Facebook, public chat rooms, Myspace, YouTube, blogging, identity theft, Build-A-Bearville, bulletin board systems, PBSKids.org, etc. If it seems like a foreign language, that's because it is. In the past decade the language of cyberspace, concerning the activities of online participation seems to be expanding every minute of every day.

Here are a few statistics that demonstrate the impact that the Internet has had on our youth:

75% of teens use Instant Messaging compared to 42% of adults (Pew Internet and American Life Project, "Teens and Technology." July 27, 2005).

Over half (51%) of parents either do not have, or do not know if they have, software on their computers to monitor where their teenagers go online and with whom they interact. (Cox Communications and The National Center for Missing and Exploited Children, "Parents' Internet Monitoring Study," February 2005).

97% of American teens ages 12-17 play some kind of video game. 99% of boys say they are gamers and 94% of girls report that they play games. (MacArthur Foundation Report, "Major New Study Shatters Stereotypes About Teens and Video Games" September 2008) Many young people game online, with strangers from all over the world.

65% of all parents and 64% of all teens say that teens do things online that they wouldn't want their parents to know about (Pew Internet and American Life Project, "Protecting Teens Online." March 17, 2005).

But while we tend to emphasize the dangers of the internet, we don't often celebrate the incredible resource that it provides our youth. A recent report by the MacArthur Foundation reports that youth are benefiting in many ways by participating in online activities. "Contrary to adult perceptions, while hanging out online, youth are picking up basic social and technological skills they need to fully participate in contemporary society." (MacArthur Foundation, "New Study Shows Time Spent Online Important for Teen Development" November 2008).

The use of digital media and communication technologies defines this generation as distinct from their elders. So how should we advise our patients' parents about their children and the Internet? How do we balance the benefits of the Internet with safety precautions?

Interested in finding out how to advise parents about their kids and the Internet? Learn more at the Los Angeles Pediatric Society Parmelee Lecture, "Cyber Checkup 2.0: What Digital Footprints Tell Us about Kids' Health" on May 14, 2008. Our featured speaker will be Dr. Bobbie Eisenstock, Media Educator and Consultant, California State University Northridge.

**Bobbie Eisenstock, PhD** specializes in the social and psychological effects of new interactive media on children, teens and families. As an educator and consultant, she focuses on using media literacy to promote healthy child and adolescent development. Her educational outreach includes lectures, workshops and professional trainings for parents, educators, health practitioners, youth advocates, and the media industry. Among the groups with whom she has worked are the American Academy of Pediatrics, Cedars-Sinai Pediatric Residency Program, Children's Hospital of Orange County, Planned Parenthood, National Youth Anti-Drug Media Campaign, National PTA, and Academy of Television Arts & Sciences. She is the author of numerous articles, reports and media guides, most recently *Cyber Harm* for Teen Line at Cedars-Sinai Medical Center, *You Are What You Post* for Cable in the Classroom, *Raising Media Savvy Children* for Common Sense Media, and the *Children, Health and Media Fact Sheet Series* for Kaiser Family Foundation, spotlighting critical issues such as media and childhood obesity, kids coping with news about terrorism and everyday violence, the effects of TV violence, video games, the online culture, and the role of media literacy education in the Digital Age. Formerly the director of The California Campaign for Kids' TV, Dr. Eisenstock is on the faculty at California State University Northridge where she currently co-directs a grant with Joint Advocates on Disordered Eating and the Health Sciences Department to develop curriculum and a webzine about media, body image, and eating disorders for college students. She also has taught at UCLA, Antioch University, and the college program for prison inmates at California Institution for Women. Dr. Eisenstock serves on the Television Academy of Arts & Sciences Blue Ribbon Panel for the Fred Rogers Memorial Scholarship and as a judge for the Media Smart Award for Cable in the Classroom.

# THE EVE AND GENE BLACK SUMMER MEDICAL CAREER PROGRAM

The Summer Medical Career Program was established by the Los Angeles Pediatric Society in 1969. The purpose of the program is to encourage high school students to choose careers in the health professions. This is accomplished by providing first hand experience observing doctors, nurses and allied health professionals at work in hospitals and through career guidance provided by counselors at each participating institution. For a period of four weeks students take part in a variety of activities affording direct contact with both the medical staff and patients. They rotate through the various departments in hospital and observe the role of health-care personnel in providing medical services. The program is different at every location and is usually tailored to meet the interests of the participants.

A weekly stipend of $75.00 is given to each student to cover incidental expenses and a certificate of completion is presented at the end of the program. In addition, two $500 scholarships are awarded each year from the Rissman/Seidel Scholarship Fund.

Funding is provided by contributions from individuals and groups, Medical Careers Unlimited Medical Group Members and our new Circle of Friends and Donors. To show our appreciation, contributions received this year for the Summer Medical Career Program or the LAPS general fund are listed below. All are cordially invited to join. You will help students get started in the right direction, just as perhaps someone helped you.

*LAPS is a private, tax-exempt, not-for-profit organization pursuant to Section 501 (c)(3) of the Internal Revenue Code.*

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**on page 10**

We regret the omission of any names. please call our office with any errors and we will print a correction in the next issue.

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The Los Angeles Pediatric Society has established the **Eve Black Memorial Fund** and the **Dr. Jim Seidel Memorial Fund** in support of the Eve and Gene Black Summer Medical Career Program.

You may make donations online with your credit card at www.lapedsoc.org or with a check made payable to the Los Angeles Pediatric Society. Mail to P.O. Box 4198 Torrance, CA 90510-4198.

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**LOS ANGELES PEDIATRIC SOCIETY APPLICATION**
**40th ANNUAL EVE AND GENE BLACK SUMMER MEDICAL CAREER PROGRAM**
**July 6 – 31, 2009**

**Applicants must be at least 16 years old and a current 11th or 12th grade high school student.**

This program is best described as a medical shadow program. Students work under the supervision of a health care professional and get a realistic view of what it is really like to be a doctor, nurse, etc. Students selected will receive a weekly stipend of $75.00. This is for parking, bus, gas, food and any other expenses incurred while participating. The program is run for the 4 weeks in the month of July ONLY, Monday through Friday, about 8 hours a day, *no nights or weekends.* The exact hours are determined by each specific hospital and its program counselor.

***Please Type or Print Clearly in BLACK INK ONLY***

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*Extracurricular Activities and Interests* _____

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*Academic and Future Career Plans* _____

**TO COMPLETE THIS APPLICATION:** These items MUST be included when submitting your completed application.

1. Type (not hand written) an essay (12pt., any font) of no more than one page about why you are interested in this program.
2. Attach one or more letters of recommendation from someone who is familiar with your abilities and interests. This can not be a family member.
3. If you need more space for "Extracurricular Activities and Interests" or "Honors or Honor Society Membership," please include this information on a separate sheet of paper. Transcripts are optional.
4. Have a school official, ie: principal, assistant principal, adviser or counselor, (not just a teacher) sign the application below.
5. Your parent or guardian MUST read and sign the consent form on the back of this application.
6. The hospitals listed below are the *only* hospitals participating in our program this year. Please indicate your 1st and 2nd choice. The second choice will only be used if the first choice hospital unexpectedly drops the program. Select carefully as you are responsible for your own transportation. **Note: Hospitals with * require students be 18 years old by start of the program.**

| | | |
|---|---|---|
| ____ ***Cedars Sinai Medical Center, LA** | ____ **LAC/USC Medical Center, LA** | ____ **St Johns Hospital/Santa Monica Hospital** |
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*Student Signature* _____ *Date* _____

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**Application Deadline: MARCH 5, 2009. Your application package must be POSTMARKED by this date.**
**APPLICATIONS ARE TO BE MAILED ONLY; the original and 1 copy of your entire application package must be sent.**
An application package consists of the following documents: both sides of this application, the essay and letter(s) of recommendation. Letter(s) of recommendation mailed separately will *not* be accepted.
**Applicants will be notified *by April 20* if accepted or not.**

**Mailing Address:** Eve and Gene Black Summer Medical Career Program
Los Angeles Pediatric Society
PO Box 4198
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Place the original and a complete copy of your application package in one envelope. This envelope will require additional postage.
**Do NOT** send your application via express or certified mail. We recommend using USPS "Delivery Confirmation."
If you have any questions visit our website www.lapedsoc.org and review the "FAQ" under the Summer Program or contact
**Mary Ellen Osborne weekdays at 310-503-1527or email at meosborne@lapedsoc.org**
For additional applications: Duplicate this one, get one from our website: www.lapedsoc.org or contact us for one as a Word doc.

los angeles pediatric society

40th ANNUAL EVE AND GENE BLACK SUMMER MEDICAL CAREER PROGRAM
JULY 6 – 31, 2009

# Consent and Agreement for Student Participation in the Eve and Gene Black Summer Medical Career Program

*As the parent or legal guardian of (Student Name)* _____

I agree as follows:

1. I give my unqualified, unconditional, and express consent for Student to participate in the Eve and Gene Black Summer Medical Career Program sponsored by the Los Angeles Pediatric Society ("LAPS").
2. On behalf of Student and myself, I waive and release all claims of every type against LAPS, its members, and any persons associated with it regardless of whether any claim is based on intentional conduct, negligence, or any other type of act or failure to act by any person or entity, known or unknown.
3. On behalf of Student and myself, I agree to indemnify LAPS and all persons or entities associated with LAPS including participating hospitals and other healthcare providers, and to hold them harmless from any liability of Student, including but not limited to all costs, expenses, and attorneys' fees.
4. On behalf of Student and myself, I agree to maintain the privacy and confidentiality of patient medical information as required by law.
5. In the event of an emergency and I cannot be reached, I consent to any medical care, treatment, or surgery necessary to the Student if there is an accident, injury, or sickness of any kind. This consent does not mean that LAPS or any person or entity associated with LAPS is under any obligation to provide medical care, treatment, or surgery.
6. If any part of this consent and agreement is held by a court to be invalid or otherwise unenforceable, the remaining portions of this consent and agreement shall remain in full force.
7. Prior to the start of the Program LAPS will require proof of immunizations plus tuberculosis test and a disclosure of medical/health problems and a list of any medication(s) currently being used. Sponsoring hospitals may require a medical release from a student's doctor before being accepted into the program. Students with medical conditions that put them at risk in a hospital setting will not be accepted into the program.
8. I have read and understood this consent and agreement in its entirety and have had the opportunity to discuss it with a representative of LAPS. By signing this consent and agreement, I intend to be bound by it in its entirety. I acknowledge that neither LAPS nor any person or entity associated with LAPS is obligated to allow Student to participate in the Eve and Gene Back Summer Medical Career Program and that my signing of this consent and agreement is a condition of any such participation.

*Parent/Guardian Signature* _____ *Date* _____

*Parent/Guardian Printed Name* _____

*Please Enter Parent/Guardian Contact Information Below:*

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## EVE AND GENE BLACK SUMMER MEDICAL CAREER PROGRAM

Would you like to participate in the Summer Medical Career Program? Do so by giving your monetary support to:

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## HELP LAPS GO GREEN

In order to save trees and trim operational costs, the Los Angeles Pediatric Society will begin emailing its newsletter, starting with the summer issue. Members will receive an email prior to the release of the summer issue that will allow them to choose their delivery option—email, US mail or website viewing. As our priority is saving trees (and all things green), if we have your e-mail and you do not specify otherwise, all future newsletters will be sent to you by e-mail.

If LAPS does not have your email address on file and you would like to receive your newsletter via email or you need to update your email address with us, please contact Ellen Seaman at eseaman@lapedsoc.org

Members who do not have an email address will continue to receive the newsletter via US mail. Thank you for supporting LAPS in this effort.

## 2008 Brennemann Lectures

If you attended this meeting, please help up track what your learned. Please fax the information below to (310) 782-9856, email meosborne@lapedsoc.org or mail to LAPS, PO Box 4198 Torrance CA 90510-4198.

Please list several specific things that you learned and/or have used in your practice from the lectures of the 08 Brennemann — Stanley Szefler, MD, Allergy and Immmunization; Marvin Ament, MD, Gastroenterology; Rena Falk, MD, Genetics; Beverly Wood, MD, MSED, PhD, Radiology

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Disneyland RESORT

# Los Angeles Pediatric Society
# 66TH Brennemann Lectures
## October 22-25, 2009

Disney's Paradise Pier Hotel

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The Los Angeles Pediatric Society is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians. The Los Angeles Pediatric Society takes responsibility for the content, quality and scientific integrity of this CME activity.

The Los Angeles Pediatric Society designates this educational activity for a maximum of 15 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity. This credit may also be applied to the *CMA Certification in Continuing Medical Education.*

The California Board of Registered Nursing has approved 15 hours of continuing medical education. Provider number is CEP11121.

**Meeting Information**
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meosborne@lapedsoc.org
Phone: (310) 533-1315

**Meeting Registration and Credit Card Payments**
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## 66th Brennemann Lectures Meeting Registration by Check

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| Tuition Fee | Before 9/22 | After 9/22 | |
|---|---|---|---|
| Physicians: Members of LAPS | $500 | $550 | $_____ |
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| Emeritus with LAPS | $150 | $200 | $_____ |

Please make checks payable to: Los Angeles Pediatric Society and return to:
P.O. Box 4198 Torrance, CA 90510-4198. **Registration must be canceled by September 21 for a full refund; after this date, an administrative charge of $35 will apply.**

## Hotel Reservation Information

*Disney Paradise Pier* ® Hotel, 1717 S. Disneyland Dr., Anaheim, CA 92802, (714) 956-6425

***NEW!* Make your room reservation online by using the following link:**
https://resweb.passkey.com/go/LAPS1009 or access this link through www.lapedsoc.org

You may also contact the hotel reservations desk directly at (714) 520-5005.

*80 rooms are available to registrants at the special rate of $165 (plus tax) per day single or double occupancy, plus resort fee of $12. These rates apply from October 19-27, 2009*
**Note: Special rates will be available only until September 30, 2009 or until all 80 blocked rooms are taken. Once these rooms are taken, regular hotel rates will apply.**

**WE RECOMMEND YOU MAKE YOUR RESERVATIONS EARLY.**
*The Los Angeles Pediatric Society disclaims any responsibility for hotel arrangements.*

## *Disneyland*® Tickets

Tickets may be purchased online until 10/18/09 using the following link: http://www.disneyconventionear.com/LAPediatricSociety09
You may also access this link from our website www.lapedsoc.org Discounted *Disneyland*® Resort Tickets ordered online are valid 10/20/09 – 10/28/09.
A limited number of *Disneyland*® tickets are available for advance purchase through the Los Angeles Pediatric Society. Tickets must be ordered by 10/05/09 and will not be available for pickup until after 6:00 pm on October 22. A ticket order form will be in our next newsletter and in the meeting brochure, which will be out later this year.

# FOOD ALLERGY: What Tests Make Sense?

**Marshall Goldberg, MD, FAAP, FAAA&I**

A complete discussion of food allergy is beyond the scope of this article but it's worthwhile to review which diagnostic procedures are at least reliable. Adverse reactions to foods can be classified into a number of categories. For the purposes of this short review "food allergy" will be defined as true IgE mediated reactions. Thus food allergy is an immunologic reaction occurring after the ingestion of food. Food allergy can be categorized based on pathophysiology. IgE-mediated, mixed-IgE and non-IgE mediated, and non-Ige-mediated reactions. These distinctions are important as they influence both evaluation and treatment. Examples of each category include:

**IgE-Mediated**
- Oral allergy syndrome (pollen-food allergy syndrome)
- Gastrointestinal anaphylaxis
- Acute urticaria and angioedema
- Anapylaxis

**Mixed IgE/non IgE-Mediated**
- Atopic dermatitis
- Allergic eosinophilic esophagitis
- Allergic eosinophilic gastroenteritis

**Non-IgE-Mediated**
- Food protein-induced proctocolitis
- Food protein-induced enterocolitis

Symptoms of IgE-mediated food allergy may involve one or all of the following organ systems: oral, gastrointestinal, cutaneous, respiratory, cardiovascular, neurologic and in some instances a sensation of "impending doom" or uterine contractions. Respiratory symptoms as the only manifestation of food allergy are rare. Nearly always there are associated skin or gastrointestinal symptoms which precede the respiratory symptoms.

Clinical judgment and a careful history are still the most important determinants as to whether to proceed with formal testing for IgE-mediated reactions. Characteristically, most IgE-mediated reactions occur quickly after ingesting the allergen, often within minutes and rarely more than two hours after eating. In some instances a late-phase reaction may occur some hours after the initial reaction. In children and adolescents milk, egg, peanut, soy and wheat account for 90% of reactions in the younger age group; peanut, fish, shellfish and tree nuts account for 85% of reactions in adolescents and adults. Putting the frequency of IgE-mediated reactions into perspective, only 6%-8% of children younger than 5 years experience IgE-mediated food reactions, with about 1.5% reacting to cow's milk, about 1.3% to egg and 1% to peanuts (but peanut allergy frequency is on the rise). It is likely that about 4% of the adult population is affected by food allergies.

If the history dictates an evaluation is appropriate, then in my opinion, one should proceed in the following manner. Allergen specific IgE testing may be performed in vivo (skin prick tests or SPTs) or via Phadia CAP system (a derivation of RAST or radioallergosorbent test). Properly performed SPTs have a high negative predictive value (>95%), but the positive predictive value is much lower at 30%-65 % (overall 50%). Therefore, a positive test only indicates sentization, which may or may not be symptomatic.

Allergen specific IgE (sIgE) can also be determined by the Phadia CAP method which has been shown to be of equal reliability to a properly performed SPT. This is a quantitative test with a reportable range of 0.1 to 100 kUA/L. Higher sIgE levels do not correlate with severity. They indicate an increased probability of a food-induced reaction. This assay has been used to define diagnostic points for certain foods. The 95% predictive values are helpful in determining which patients are at highest risk of developing a reaction and in whom oral challenges may not be advisable. There are unfortunately limitations to ImmunoCAP as patients (up to 20%, depending on the food) may react to a food despite very low or undetectable levels of food sIgE. Among children with elevated sIgE to food as per ImmunoCAP, those without a clear history of a food reaction were more likely to be tolerant to the food. Thus, sensitization may be symptomatic (food allergy) or asymptomatic (food tolerance).

History, history, history!

Double Blinded Placebo-controlled Food Challenges (DBPCFCs) are the gold standard for diagnosis. These are impractical in most practice settings. However open or even single-blind challenges can be performed in an office setting provided emergency medications are available and trained personnel are at the ready.

SPTs and ImmunoCAP in summary may both be utilized for diagnostic purposes as long as one is familiar with the limitations of these tests, selects the food antigens based on a carefully-taken history and interprets the results based on available norms. ImmunoCAP may be preferable if skin testing can not be done (severe eczema, patient cannot be weaned off antihistamines, etc.) or if quantification is desirable (serial determinations showing decreasing levels in a range where challenge may be safely considered). SPTs offer information within 15 minutes, do not require a venapuncture and are less expensive. Use clinical judgment for each patient.

Now, how about controversial and probably tests of no value? These include food-specific IgG or IgG4 antibody levels, food-antigen-antibody complexes, evidence of lymphocyte activation, and sublingual or intracutaneous provocation. Intradermal skin testing also has no role in the evaluation of IgE-mediated food reactions and for that matter is rapidly growing into disfavor as a diagnostic tool for pollen and inhalant allergy as well, due to unacceptable false-positive reactivity and a lack of clinical correlation. I should mention that most individuals make some IgG antibodies to foods they ingest, and an absence of food-specific IgG might suggest that a child has immunodeficiency.

One point of interest is the increasing use of atopy patch testing in association with tests for sIgE in the evaluation of Eosinophilic Gastrointestinal Disorders. In theory patch testing is useful in the detection of non-IgE-mediated contributions to the eosinophilic disorders and as well in eczema. However, the technique should be considered somewhat controversial and still investigational at this time.

So eat heartily and keep your epinephrine handy!

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See page 6

**October 22-25, 2009**
*66th Brennemann Lectures*
*Disney's Paradise Pier*® Hotel
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See page 14.

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