AMERICAN ACADEMY OF PEDIATRICS

Section on Pediatric Pulmonology

*Summer/Fall 2005*

# Chairperson's Report

Time flies, at least it seems to based on the fact that I am half way through my stint as Chairperson. And yet, it seems that some changes proceed at a snail's pace. The Executive Committee has defined a number of goals and although there has been progress it seems as if it takes a long time to make a difference.

One of our goals has been to stimulate communication amongst the community of pediatric pulmonology. We proposed evaluating the potential of an international registry of professionals who work in the field of pediatric pulmonology. The concept was that it would be useful to know who was working in a particular geographic area, as well as being able to identify who was working in a particular field of the subspecialty – both in the research arena as well as the clinical arena. We considered that the Internet provided the best opportunity to achieve this and then found that other groups had similar ideas but different approaches to reach the same goal. And so we have allied ourselves with them, because the last thing we want to do is to duplicate efforts. I hope to report further developments in this "Pediatric Pulmonology Network" in the near future.

As a member of the ATS Task Force on Spirometry, I have been interested in assessing the utility of spirometry in the pediatric primary care office. When I asked for a show of hands at an educational seminar, 40-50% of pediatricians said that they had access to pulmonary function testing in their office and a further 20-30% said that they were interested in the concept. This was far from an accurate poll, but I was surprised at the number who had access. To look into this further, we, in conjunction with the Section on Allergy, submitted a request to the Academy to develop a clinical practice guideline for spirometry in the primary care pediatric office. This guideline takes about 2 years to develop.

We have made progress in that the past chairperson of the ATS Pediatric Assembly and of the ACCP Chest Network have been invited to participate as non-voting members of the SoPPu Executive Committee. It was disappointing that the section was not presenting at the recent NCE meeting in Washington but the future looks better. In 2006 we will have a number of presentations including a Pulmonology Program for Section Members. In addition we are working with the Section of Allergy to have a joint session for 2007.

As always, I encourage everyone to communicate with members of the Executive Committee and welcome any ideas or suggestions for projects that we can work towards our unified goal of improving the field of pediatric pulmonology.

*Michael Light, MD, FAAP*
*Chairperson*

## Executive Committee

**Chairperson**
Michael Light, MD
Chairperson-Elect
Christopher Harris, MD
**Executive Commitee:**
Steven Boas, MD
Albert Faro, MD
Andrew Gelfand, MD
David Gozal, MD
Julie Katkin, MD
Jeffrey Wagener, MD
**Immediate Past Chairperson**
Michelle Howenstine, MD
**AAP Staff:**
Laura Laskosz, MPH

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**Celebration of Pediatric Pulmonology 2006**
**March 31 - April 2, 2006**
**San Juan, Puerto Rico**

# Join us for the Celebration of Pediatric Pulmonology 2006!

Course Directors:
LeRoy M. Graham, MD, FCCP
Dennis Gurwitz, MB, BCh, FAAP

Cosponsored by the American College of Chest Physicians (ACCP) and the American Academy of Pediatrics (AAP), the Celebration of Pediatric Pulmonology 2006 is brimming with presentation topics selected in response to frequent requests by previous attendees and for their current pertinence to issues facing today's pediatric pulmonologist. Attendees will participate interactively in sessions with audience response capability to increase their learning potential, enhance their critical thinking skills, and hear the latest information being discussed in the field. The workshops are intended to provide an intimate atmosphere for the attendees and a facilitator who will lead a case-based presentation. As each title suggests, the topics can easily evolve into very detailed or broad discussions depending on the attendees. Participants are also encouraged to bring forth problem cases for discussion. By design, the informal setting encourages maximum audience participation. This program will benefit pediatric pulmonologists, general pediatricians, family physicians, pediatric intensivists, allergists, and allied health professionals, such as pediatric nurse practitioners and respiratory therapists.

Goals

1. To provide an update of clinical topics for pulmonologists and other specialists who care for children with respiratory disorders.
2. To review the latest research findings as they relate to pediatric lung disease.
3. To provide a forum for interactive discussions between clinicians handling complex cases.
4. To explore current controversies in pediatric pulmonology.

Objectives
This continuing medical education program is intended to provide a state-of-the-art update in clinical pediatric pulmonology. The course content includes infectious disease, radiology, and pediatric surgery, as well as selected pulmonology topics, such as asthma, cystic fibrosis, sleep medicine, and the impact of lung disease on a child's well being. All have been designed to include the latest research findings. This will allow the attendee to update his or her practice. The course will combine plenary-style lectures, question and answer sessions, interactive small group workshops, and case presentations. Attendees will benefit from this wide variety of clinical topics presented by experts in the field of pediatric pulmonology.

NEED MORE INFORMATION?
Access www.chestnet.org/education/calendar/
for up-to-the-minute registration and course information (coming soon).

# Black Box Warning for Long-Acting $ß_2$ Agonists: Misguided or Valid Concern

*Miles Weinberger MD*
*Professor of Pediatrics*
*Director, Pediatric Allergy & Pulmonary Division*
*University of Iowa*
*www.uihealthcare.com/allerpulm*

There has been an ongoing debate regarding the safety of inhaled $ß_2$ agonist therapy, especially when used indiscriminately in frequent and/or high doses. This issue stimulated particular controversy in this country in 1984 when metaproterenol was made available without a prescription, a decision that was reversed after three months by the Food and Drug Administration following an emergency meeting of the Pulmonary Allergy Advisory Committee to the FDA.[1] The argument was made at that time that inhaled $ß_2$ agonist therapy, however beneficial for initial treatment of acute bronchospasm, had associated dangers related to the very efficacy that encouraged patients to use this type of medication frequently and even excessively when airway obstruction from asthma was progressing. Delay in seeking further medical care could then result in delays in beginning corticosteroids. This then permits the inflammatory component of airway obstruction to progress with consequent mucosal edema, mucous secretions, and the resulting potential for an asphyxial death.

Although the safety of salmeterol has been well established when it is used as recommended, risks have been suggested in clinical practice. In a double-blind, randomized, parallel-group surveillance study published in 1993, 2 inhalations of salmeterol twice daily were compared with 4 times daily inhaled albuterol to a total of more than 25,000 patients followed in multiple primary care settings. A fatality rate of 0.07% was found among those receiving salmeterol while only 0.02% of patients died in the albuterol treated patients.[2] However, these differences in fatality rate did not reach statistical significance ($p = 0.1$). Moreover, all deaths were reported to occur in patients with severe asthma and were judged to have been avoidable with appropriate intervention. A suggestion that the use of salmeterol may present an increased risk to the elderly was published as a letter to the editor that reported deaths in two patients found holding their inhalers.[3] This was followed by reports in the lay press, including the Chicago Tribune (November 16, 1994) and the Philadelphia Inquirer (November 17, 1994), that as many as 20 asthma patients may have died as a consequence of the possible misuse of salmeterol. In a January 16, 1995 letter distributed widely to physicians by the manufacturer of salmeterol, Dr. James Palmer, senior vice president and chief medical officer of Allen & Hanbury, acknowledged that "serious acute respiratory events, including fatalities, have been reported (both in the United States and worldwide) in patients receiving serevent inhalation aerosol (salmeterol)." He further stated that these patients generally had severe asthma that was worsening. When salmeterol was reviewed by the Pulmonary Allergy Advisory Committee to the FDA in 1993 prior to marketing approval, data was presented indicating that modest over-dosage could cause concerning prolongation of the QTC interval suggesting the potential for arrythmias. However, there is no suggestion that this presents a risk at recommended doses.

And know we have the results of the Salmeterol Multi-center Asthma Research Trial. Based on previous experience, the SMART study, as it is commonly known, does not appear to have been very smart. This study, which was the basis for the FDA's decision in 2003 to issue a warning regarding the use of salmeterol, was begun by GSK in July 1996 to assess the safety of Serevent (salmeterol) in a 28 week placebo controlled trial. Although the study was intended to enroll 60,000 patients, the sponsor stopped the study after about 13,000 patents had received Serevent and another 13,000 had received placebo. The analysis showed no statistically significant difference between treatment groups but there were 13 asthma related deaths or life-threatening experiences in the Serevent treated group and only 7 in the placebo group. Of particular concern was the presence in the Serevent treated African-American patients for statistically significantly greater asthma related deaths (8 vs. 1) and life-threatening experiences (19 vs. 4).

The SMART study, like the previous study in the U.K.,[2] involved adding salmeterol or placebo to whichever asthma medication the patients were or were not receiving without close monitoring of drug usage or asthma control other than life-threatening episodes. Population studies have identified increased risk from continuous scheduled use of $ß_2$ receptor agonists in general.[4,5] Thus, the risks are not unique to the long-acting $ß_2$ agonists, salmeterol and formoterol. Recent investigations have identified that certain subpopulations may be at greater risk because of the particular genetic polymorphism of their $ß_2$ receptors, which results in down-regulation when there is repeated use of $ß_2$-adrenoreceptor agonists.[6] Patients with such polymorphisms may then fail to respond adequately to a rescue inhaler when asthma increases.

However, even without an increased genetic risk factor for some patients, asthma deaths or life-threatening events most commonly occur when too little is done too late and the patient utilizes only a bronchodilator, regardless of whether it is albuterol or salmeterol during a period of worsening symptoms.[1,7] Intervening with a short course of oral corticosteroid for acute exacerbations and the use of maintenance inhaled corticosteroids for persistent disease greatly decreases the risk of fatalities or even progressive exacerbations that result in emergency care or hospitalization.[8,9]

So where do we stand with the use of the long acting $ß_2$ agonists, salmeterol and

*continued on page 6*

# Medical Home Training Curriculum

**"The planning process and the training program mobilized our community of providers that care for children with special health care needs (CSHCN) and hopefully enlightened legislatures as well."**
– Matthew Sadof, MD, FAAP: Baystate Medical Center Children's Hospital

The *Every Child Deserves A Medical Home* training curriculum developed through a partnership between the American Academy of Pediatrics and the Shriners Hospitals for Children, is an excellent resource to increase awareness of medical home concepts and practices among primary care providers, pediatric office staff, child health advocates, allied health care professionals, and parents. The medical home training program focuses on how to ensure that all children, especially those with special needs, have a medical home (care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent) in changing health care environments.

The medical home training curriculum includes; a planning guide, "How to Host", facilitator manual, POWERPoint slides, marketing materials, evaluation tools, logistical guidance, participant handouts, tools, and resources. This training curriculum was written and reviewed collaboratively by 75 authors throughout the country and is one of a kind. The materials are not copyrighted so they may be adapted to your local community's needs. The curriculum can be used by child health professionals and families to increase awareness during staff or community meetings, grand rounds, continuing medical education opportunities, resident trainings, conferences, advocacy events and/or seminars. Practical strategies are provided in the medical home training program with the expectation that participants will use them to increase access to medical homes for all children, especially those with special health care needs.

To receive assistance in implementing medical home training programs in your community or practice, the following are available at no cost: master copy of training curriculum, ongoing technical assistance throughout the planning process, AAP website space to promote medical home training in your community, assistance in obtaining CME credit, venue and funding search. Please contact Jennifer Marks MPH, Training Manager at ***jmarks@aap.org*** or call 800/ 433-9016 ext. 4924 for more information.

***To obtain your complimentary copy of the* Every Child Deserves A Medical Home *curriculum please contact the National Center at 800/433-9016 ext 4924, e-mail at jmarks@aap.org or download the materials at the National Center Web site at: http://www.medicalhomeinfo.org/training/materials.html***

## We would like to welcome the following new members into the section!

The following people have joined the section or reactivated their membership during the last 6 months. If you know of others who might be interested in joining our section, please have them call 800/433-9016, ext. 5897 for an application or visit the web site www.aap.org. For More Information, please visit the AAP Membership web site at www.aap.org/member/memcat.htm. Current members of the Academy in good standing are eligible to apply online by following the instructions below:

1. Log on to the AAP Member Center (www.aap.org/moc)
2. Once logged in, click on "Member Services" (located on the right side of the screen)
3. Click on the link titled, "Online Section Membership Applicationm"
4. Once the form appears, follow the simple instructions shown:

- Select the Section(s) that you are interested in
- Complete the demographic information (optional)
- Select the "Submit" button

Aileen Abesamis, MD
Amit Agarwal, MD
Michael Aguinaldo, MD
Carrie Barker, MD
Glenda Bendiak, MD
Nicholas Blanchette, MD
Hollis Chaney, MD
Shivani Choudhary, MD
Heidelene Espinosa De La Rosa, MD
Rachel Galagher, MD
Sonia Jain, MD
Adaobi Kanu, MD
Ana Kato, MD
Gwendolyn Kerby, MD
Hye Kim, MD
LCDR. Rees Livingston Lee MD
Gary McPhail, MD
Duyen Nguyen, DO
Patricia O'Brien, MD, PhD
Matthew Payne, MD
Guillermo Paredes, MD
Isabel Rojas, MD
Jorge Sallent, MD
Jordan Scalo, MD
Karen Schultz, MD
Ewurabena Simpson, MD
Steven Snodgrass, MD
Charles Thompson, MD
Tiffany Turner, MD
Stefan Worgall, MD
Harry Yuan, MD

## Update your Profile on the AAP Member Center

An important service is available on the AAP Member Center. A Personal Profile has been added to provide you with an opportunity to view your address, demographic, and subspecialty information and update it at your own convenience. Simply enter the changes into the form and our database will be updated the following day. This way, there will be no delay in receiving your member benefits.

The AAP online Member Directory, available through the AAP Member Center at , has recently been improved. The online Directory should be your primary resource to locate colleagues. Quite simply, it has the most accurate, up-to-the-minute contact information available.

With these new changes and enhancements, we believe we can further improve service to members and the public. However, it is also an important time for our members to check their address and demographic in formation for accuracy. Please take the time to visit the Member Center and click on "Update my Personal Profile." If you prefer to contact us by phone or e-mail, you can call 877/THE-AAP1, or send an e-mail to csc@aap.org.

## Section on Pediatric Pulmonology Trainee Travel Award
## Celebration of Pediatric Pulmonology 2006

SOPPu Travel Award will be available for pulmonary fellows currently in training. These awards will provide complimentary registration to the "Celebration" CME course and a maximum of $1200 reimbursement for airfare, three nights hotel, meals, and ground transportation to attend the course.

To be considered:

- Complete the form on page 10 and return by December 2, 2005
- If selected, be prepared to present a brief case study during the meeting

**Questions?**
**For additional information, contact the American Academy of Pediatric Section on Pediatric Pulmonology: E-mail llaskosz@aap.org**

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formoterol? Should the new FDA warnings alter our use. For effective asthma management, a low dose inhaled corticosteroid is the treatment of choice for asthmatic symptoms that are persistent. When a low dose of inhaled corticosteroid is inadequate for control, the combination of an inhaled corticosteroid and a long-acting $ß_2$agonist such as salmeterol or formoterol is generally more effective than a higher dose of inhaled corticosteroid. However, if a patient reports that they have less bronchoprotective effect from their rescue inhaler while receiving a long-acting$ß_2$ agonist, consideration must be given to the possibility that the patient may have the type of $ß_2$ receptors for which additive maintenance therapy with theophylline or montelukast may be preferable. Nonetheless, that scenario appears to be clinically uncommon, and even that situation is unlikely to result in risk of fatal or near-fatal reactions in a patient being appropriately treated and monitored. A badly conceptualized study such as the SMART study and the previous British study should primarily warn us about the need to monitor the clinical course of asthma and to ensure that intervention measures are available and appropriately instructed and that maintenance medication includes an inhaled corticosteroid.

References


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4. Spitzer WO, Suissa S, Ernst P, Horwitz RI, Habbick B, Cockcroft D, Boivin JF, McNutt M, Buist AS, Rebuck AS. The use of ß-agonists and the risk of death and near death from asthma. N Engl J Med 1992; 326:501-6.
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7. Benatar SR. Fatal asthma. N Engl J Med 1986;314:423-9.
8. Najada A, Abu-Hasan M, Weinberger M. Outcome of Asthma in Children and Adolescents at a Specialty Based Care Program. Ann Allergy Asthma Immunol 2001;87:335-343.
9. Suissa S, Ernst P, Benayoun S, Baltzan M, Cai B. Low-dose inhaled corticosteroids and the prevention of death from asthma. N Engl J Med 2000;343:332-6.


## Section on Pediatric Pulmonology Executive Summary March 2005

*Rancho Las Palmas Marriott*
*Rancho Mirage, CA*
*March 17, 2005*

The Section on Pediatric Pulmonology Executive Committee met on Thursday, March 17, 2005 in Rancho Mirage, CA. The meeting was held in conjunction with the American Academy of Pediatrics/American College of Chest Physicians (ACCP) CME course, "Celebration of Pediatric Pulmonology."

The SOPPu discussed staggering of the terms of the members on the Executive Committee and will convey this information to the Nominations Committee.

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## Upcoming Meetings

**Celebration of Pediatric Pulmonology 2006**
March 31 - April 2, 2006
San Juan Marriott
San Juan, PR
www.chestnet.org

**AAP National Conference and Exhibition**
TBD

**CHEST 2006**
October 21 - 26, 2006
Salt Lake City, UT
www.chestnet.org

*Statements and opinions expressed in this publication are those of the authors and not necessarily those of the American Academy of Pediatrics*

**Interested in writing an article for the newsletter?**

**Submit your suggestions to Laura Laskosz at llaskosz@aap.org**

## 2006 Elections
## Call for Nominations
## Due Dec. 1, 2005

The American Academy of Pediatrics seeks nominees to run for election to the Section on Pediatric Pulmonology Executive Committee.

The successful Executive Committee Member candidate will serve a three-year term, to begin immediately following the 2006 AAP National Conference and Exhibition.

Summaries of responsibilities for the AAP Section Executive Committee Member is listed below. Each Section will appoint a nominations committee to review the nominees and select the candidates for the ballot. Submission of this form does not guarantee inclusion on the ballot.

If you would like to be considered for candidacy or if you would like to nominate a colleague, please:

E-mail your name, address, telephone, fax, and e-mail along with a brief biographical sketch (maximum of 250 words) to Carolyn Mensching cmensching@aap.org or fax 847/434-8000, Attention Carolyn Mensching, prior to December 1, 2005.

## Section Executive Committee Member
## Summary of Responsibilities

*Basic function*: Actively participates in the work of the section. Provides thoughtful input to the deliberations of the executive committee. Focuses on the best interests of the Academy and the Section rather than on personal or constituent interests. Works toward fulfilling the section's goals. Reports to the section chairperson.

- Reviews all relevant material before meetings. Makes contributions and voices objective opinions on issues.
- Attends all meetings and conference calls.
- Volunteers to take the lead in section activities appropriate to expertise.
- Carries out individual assignments made by the chairperson and/or staff.
- Works as part of the executive committee/staff team to ensure that the executive committee's projects help AAP members, children, and staff who are responsible for the section's programs.
- Represents the section in meetings of other sections, committees, or organizations as directed by the Academy.
- Serves as spokesperson on behalf of the Academy to the media, outside organizations, and others as requested by the Academy.
- Focuses attention on the section's role and how it supports and fits with the interests of the Academy and its strategic plan.
- Assists the membership committee or its equivalent in the evaluation of applicants.
- Discusses any activity which may involve a fiscal note with the chairperson and staff.
- Discloses potential conflicts of interest.

Members of the executive committee may be appointed to a specific role or subcommittee. These roles and their responsibilities include, but are not limited to, the following:

**Section Vice Chairperson, or Chairperson-Elect**

⇒ Serves in an advisory capacity to the section executive committee (where applicable).

⇒ Alleviates the chairperson work overload.

⇒ Undergoes orientation prior to beginning his or her term as chairperson.

⇒ Carries out specific duties at the discretion of the executive committee and the Chairperson, including the duties of a core executive committee member.

**Section Program Chairperson**

⇒ Leads the section's educational programs for the AAP National Conference and Exhibition and other educational activities and writes proposals as necessary.

⇒ Follows the National Conference and Exhibition Planning Group (NCEPG) guidelines for program submission.

⇒ Works collaboratively with the section's NCEPG representative on program development.

⇒ Involves related committees/sections in educational planning as appropriate.

⇒ May also serve as abstract chairperson, publications chairperson, or local arrangements chairperson to organize various components of the educational program.

**Secretary/Treasurer**

⇒ Takes the minutes of executive committee meetings in the absence of staff or if specifically assigned to do so by the section chairperson.

⇒ Takes the minutes of the Annual Business Meeting.

⇒ Carries out such other duties as are assigned by the section chairperson.

⇒ Is responsible for understanding the section's budget and reviewing all budget reports submitted by staff for presentation to the executive committee at all meetings.

**Membership Chairperson**

Reviews section applications, in accordance with established bylaws, up to four times annually in order to facilitate proper review of the applications and supporting documents.

⇒ Reviews all incoming applications for section membership and presents new applicants to the executive committee for a vote at each executive committee meeting.

⇒ Works with the Section Manager to resolve issues about applications.

⇒ Works with the Section Manager to draft recruitment letters.

⇒ Works with the Section Manager to obtain mailing lists for recruitment efforts.

⇒ Works with the Section Manager to develop a plan for recruitment and retention of members.

⇒ Works with the Section Manager to develop a package of benefits for section members.

References:

Schlegel JF. *Enhancing Committee Effectiveness: Guidelines and Policies for Committee Administration*. American Society of Association Executives.

AAP Sections Bylaws Template

*Just the Facts: The Section Executive Committee Member's Handbook, 2001-2002*

*Continued from page 6*

The SOPPu Executive Committee agreed to continue the co-sponsorship of the "Celebration of Pediatric Pulmonology" for 2006 and 2007. Puerto Rico will be the location for the 2006 course. The SOPPu will continue to sponsor the Edwin L. Kendig, Jr Award and several travel grants to pediatric pulmonary fellows to attend the course. New for 2006 will be the requirement for the fellows to present a short case discussion (10 - 15 mins) during the 2006 course.

The Section is waiting final approval to develop Academy policy on bronchopulmonary dysplasia and will submit a request to develop policy on spirometry for the primary care pediatrician.

A online CME module developed by members from the Section on Allergy and Immunology along with members from the Section on Pediatric Pulmonology, "Asthma Gadgets" is available at www.pedialink.org. The goal of the module is to increase knowledge about the proper use, technique and care of asthma medication delivery devices and patient aids for self-management.

The Section will be contacting the American Thoracic Society and the American College of Chest Physicians to establish liaison representatives from each organization. Potential areas of collaboration include the development of an international registry of pediatric pulmonologists and recruitment into the field of pediatric pulmonology.

The next meeting will be held March 2006 in conjunction with "Celebration of Pediatric Pulmonology 2006"

For a complete set of minutes or further information on specific items discussed at this meeting, please contact the Division of Technical and Medical Services, at 800/433-9016 extension 4928.

*This is privileged information. Contents Review and refer to appropriate have not been reviewed for accuracy and may not represent AAP policy.*

## New, revised ICD-9-CM codes to take effect on Oct. 1

For 2006, there are about 180 new codes, revisions and deletions to ICD-9-CM. Below is a sample of codes of most interest to pediatric pulmonologists. Of note is a new specific code for obstructive sleep apnea.

**New Codes**

278.02 Overweight
327.20 Organic sleep apnea, unspecified
327.21 Primary central sleep apnea
327.22 High altitude periodic breathing
327.23 Obstructive sleep apnea (adult) (pediatric)
327.24 Idiopathic sleep related non-obstructive alveolar hypoventilation
327.26 Sleep related hypoventilation/ hypoxemia in conditions classifi able elsewhere
327.27 Central sleep apnea in conditions classified elsewhere
327.28 Other organic sleep apnea
799.01 Asphyxia
799.02 Hypoxemia

V12.60 Personal history, unspecified disease of respiratory system
V12.61 Personal history, pneumonia (recurrent)
V12.69 Personal history, other disease of respiratory system
V46.13 Encounter for weaning from respirator [ventilator]
V46.14 Mechanical complication of respirator [ventilator]

**Revised Codes**

780.51 Insomnia with sleep apnea, unspecified
780.52 Insomnia, unspecified
780.53 Hypersomnia with sleep apnea, unspecified
780.54 Hypersomnia, unspecified
780.57 Unspecified sleep apnea

**Invalid codes**

799.0 Asphyxia
V12.6 Disease of the respiratory system

These changes will become effective October 1, 2005. The entire list can be obtained from the National Center for Health Statistics Web Site at www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guidelines or by calling Linda Walsh, AAP Division of Health Care Finance and Quality Improvement, at (800) 433-9016, ext. 4928.

The Academy offers a fax-back coding hotline at (800) 433-9016, ext. 4022, or e-mail aapcodinghotline@aap.org.

## Section RVU Chair Needed

The Section is currently soliciting (a) volunteer(s) to serve as the Section RVU liaison to the AAP Committee on Coding and Nomenclature. Responsibilities include:

- Work with Academy staff on methods to improve coding/ reimbursement issues for pediatric endocrinologists
- Evaluate and assess impact of related RBRVS information received from the AAP Committee on Coding and Nomenclature
- Maintain a list of section members interested in working on coding/reimbursement issues

If interested, please contact Laura Laskosz, MPH, Section Manager at llaskosz@aap.org or (800) 433-9016, ext. 4928 or Michael Light,
MD, FAAP, Section Chairperson at mlight39@yahoo.com or 305/345-5751.

## Asthma Gadgets Online Learning Module May 10 - 31, 2008

Visit www.pedialink.org
AMA PRA category 1 maximum of 7.0 credits

**Description:**
Asthma is one of the most common chronic childhood diseases. However, asthma CAN be successfully controlled with regular use of controller medications, managing environmental triggers, and adherence to an asthma management plan.
Clinical success of asthma inhaled therapy is directly associated with proper use of the inhaled medication. This module will explore the technique for five major asthma devices: metered-dose inhalers, spacers and holding chambers, dry power inhalers, nebulizers, and peak flow meters.

**Objectives:**
The goal of this module is to increase knowledge about the proper use, technique and care of asthma medication delivery devices and patient aids for self-management
You will:

- Become familiar with the most common accessories and gadgets used in treating and managing asthma in children.
- Learn how pediatric patients should properly use their metered dose inhaler, dry powder inhaler, spacer, nebulizer, and peak flow meter.
- Select the proper inhaled delivery system appropriate for the age and maturity of the child.
- Understand the advantages and disadvantages of different inhaled delivery systems for treatment of asthma in children.
- Appreciate that correct use of asthma inhaler devices is critical to achieving success with an inhaled medication.
- Develop an awareness that teaching and re-teaching of proper inhaler and device use needs to be an office-wide process, and that all allied health professionals in the office should be educated on proper asthma gadget use and how to educate patients on proper use.

## Edwin L, Kendig, Jr Award for Lifetime Achievement in Pediatric Pulmonology

The Section on Pediatric Pulmonology is please to announce that Lynn Taussig, MD has been seleced to receive the 2006 Edwin L. Kendig, Jr Award for his significant contributions to Pediatric Pulmonology.

Dr Taussig is one of the founding fathers of modern pediatric pulmonology and has excelled in virtually all spheres of our discipline including innovative research, superior education, clinical program development, and has demonstrated a remarkable degree of accomplishment as an administrator.

*Distinguished clinical service and dedication to patient care*: Dr Taussig has been dedicated to patients while on faculty at the University of Arizona or as the CEO of one of the largest pulmonary hospitals in the world. Patients travel across the country to be seen by him and often he sees his patients into adulthood or his one-time childhood patients return to have their children seen by him.

*Significant contribution to clinical or basic science research in the field of pediatric pulmonology*: Dr Taussig has trained numerous fellows and was involved in early and pivotal research in pediatric pulmonary disease and physiology, including initiation of the Tucson Children's Respiratory Study (CRS) or "Tucson study of early lung disease" This study has resulted in several publications directed to understanding the development of asthma and recognizing the many different triggers and pathways these patients may follow. Using this database, current investigators are successfully identifying some of the genetic risk factors for asthma. Dr Taussig is also known for his many contributions to research in Cystic Fibrosis, croup, and other lung diseases in children. While at NIH, he helped develop the prognostic scoring system for survival in CF and develop animal models for bronchiolitis and asthma

*Dedication to the education of pediatric pulmonary fellows or students:* Dr Taussig has been the primary mentor for 23 pediatric pulmonary fellows, many that have gone on to become program directors, section heads, and department chairs. He has been the senior contributing editor of one major pediatric pulmonary textbook and has authored and/or edited several other books pertaining to pediatric pulmonology. Furthermore, he has often been asked to speak at prestigious lectureships and visiting professorships, as well as other educational symposia.

**The Edwin L. Kendig Jr Award Presentation**

**Please join us at the Celebration of Pediatric Pulmonology CME Course as the Edwin L. Kendig, Jr Award is presented to Lynn Taussig, MD**

**Friday, April 1, 2006**

**7:30 am - Sixth Annual Edwin L. Kendig Jr Award presentation**

**7:40 - 8:20am - Kendig Honorary Lecture presented by Lynn Taussing, MD**

**San Juan Marriott**
**San Juan, Puerto Rico**

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

# 2006 Section on Pediatric Pulmonology Trainee Travel Award Application

Section on Pediatric Pulmonology Trainee Travel Award

SOPPu Travel Award will be available for pulmonary fellows currently in training. These awards will provide complimentary registration to the "Celebration" CME course and a maximum of $1200 reimbursement for airfare, three nights hotel, meals, and ground transportation to attend the course. To be considered:

- Complete and return the form below by **December 2, 2005**
- **If selected, be prepared to present a brief case study during the meeting**

Questions?
For additional information, contact the American Academy of Pediatric Section on Pediatric Pulmonology: E-mail llaskosz@aap.org

Name ____________________ Degree ____________________
Institution ________________________________________
Department ________________________________________
Address ________________________________________
City ____________________ State __________ Zip __________
Country ________________________________________
Phone ____________________ Fax ____________________
E-mail ________________________________________
Trainee Status: ________________________________________

I certify that ______________________________ (the nominee)
Is currently a trainee at ______________________________
________________________________________

______________________________ ______________________________
Fellowship Director (print name) Signature