



## Chair's Column

Donna A. Caniano, MD



This year the Section on Surgery celebrates its *fifty-seventh* anniversary as the oldest and largest surgical specialty organization within the American Academy of Pediatrics. The Executive Committee, your elected leadership, continues to explore all avenues that keep the Section vital and responsive as a source of professional education for the membership and of advocacy for our pediatric surgical patients. This newsletter highlights the ongoing activities of the Section during the past year. We introduce two "new" features: a column that describes recent articles written by our members and published in *Pediatrics*, and an update on American Board of Surgery issues from **Keith Georgeson**, chairperson of the Pediatric Surgery Board. We are pleased to report to you that henceforth the annual Section on Surgery meeting will take place at a hotel rather than the convention center, in response to the positive feedback from last year's arrangements. Also, beginning this year the scientific sessions for both the Section on Surgery and the Section on Urology will take place at the same hotel, since many members enjoy attending portions of each Section's respective program.

### NCE 2005

The annual meeting of the Section on Surgery will be held in conjunction with the National Conference & Exhibition (NCE) of the AAP in Washington, D.C. on October 7-9, 2005. All scientific sessions will occur at the Grand Hyatt Hotel which is within walking distance to the Washington Convention Center. The Program Committee, under the leadership of **Fred Ryckman**, has organized outstanding scientific sessions that nicely balance basic science and clinical presentations, including symposia on new concepts in wound healing and burn care, complex tumor management, and gastroesophageal reflux. Please see pages 3-4 for a summary and detailed listing of program activities.

The Section will hold its annual banquet at the Egyptian Embassy as guests of the ambassador, his Excellency Nabil Fahmy. The Local Arrangements Chairperson, **Alfred Chahine**, has organized a magnificent feast of Middle Eastern food that will be enjoyed in a heated tent in the embassy courtyard. We believe that the banquet will be an event memorable for its unique venue and delicious food!

### Other Section News

In 2002 the Section experienced a decline in membership that was attributed to several reasons: failure of emeritus fellows to renew their membership in light of the annual dues of \$50; concerns by several fellows about the high cost of Section and AAP membership in relation to other surgical associations; and inadequate numbers of new Section Affiliate members from the ranks of the residents in pediatric surgery accredited training programs. We have undertaken steps to address these issues. Fortunately, many of our emeritus fellows have renewed their Section membership in the past two years. At the yearly Pediatric Surgery Residents Conference that is held in conjunction with the annual Section on Surgery meeting, **Bob Arensman**, a previous Section Chairperson, has agreed to be a regularly scheduled speaker. He will acquaint the residents with the role of the Section and

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### AAP Section on Surgery Election Results

The Nominating Committee selected two highly respected pediatric surgeons to run for a position on the Executive Committee. They were Drs. **Mary Fallat** of Louisville, Kentucky and **Robert Shamberger** of Boston, Massachusetts. The Section elected Dr. Shamberger with a vote of 58% of the eligible members. Dr. Shamberger is the Robert E. Gross Professor of Surgery at the Harvard Medical School and Chief of Surgery at the Boston Children's Hospital. Dr. Shamberger is a leader in the clinical management of solid tumors and in the design of multi-institutional protocols through the Children's Oncology Group. He is a member of several professional surgical organizations, including the American College of Surgeons, the American Pediatric Surgical Association, the American Surgical Association, and the New England Surgical Society. He serves as an associate editor for *The Journal of Pediatric Surgery*.

The members of the Nominating Committee were **Thomas Weber**, **Mary Brandt**, and **Frederick Rescorla**.

### Highlights of This Issue...

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## Chair's Column (continued from page 1)

the AAP in their professional lives and the advantages of joining during their residency, when annual dues are significantly reduced for Section Affiliate members. This year, I sent letters to all of the program directors of accredited pediatric surgery training programs in the United States and Canada requesting that they encourage their residents to join the Section and consider defraying the cost of Section Affiliate membership (\$60 annual dues) for their residents. Finally, the high cost of joining our professional organizations must be continuously evaluated by the membership and its elected leadership. We must strive to communicate with the membership about the value of Section on Surgery and AAP membership in terms of our professional work, ongoing education through meeting attendance and reading of *Pediatrics*, and advocacy for the well-being and health of America's children. In turn, we ask you, the members of the Section to keep us informed about your professional needs and how best the Section and the AAP can meet your concerns.

Our representative to the AAP Surgery Advisory Panel, **Richard Azizkhan**, continues to advocate for issues that will improve surgical specialty care for children, as well as strengthening the educational content in the surgical disciplines for sessions offered to the general pediatricians at the annual NCE. An important example of the work of the Surgical Advisory Panel was the publication in 2002 of the Guidelines for Referral to Pediatric Surgical Specialists, which outlined optimal care for children who require evaluation by one or more of the seven surgical specialties within the AAP: pediatric surgery, ophthalmology, otolaryngology, orthopaedics, urology, neurological surgery, and plastic surgery. The untiring efforts of two former Section Chairpersons, **Arnold Coran** and **Ann Kosloske**, made this document a reality after many years of development.

Progress is being made in collaborative ventures with other AAP sections

and committees. At the 2004 meeting in San Francisco a joint session between the Sections on Surgery and Gastroenterology focused on intestinal dysmotility, providing an opportunity for leading experts in this area to present the most recent information on management of these challenging patients. For the 2006 annual meeting in New Orleans, plans are underway for a joint session with the Section on Urology on challenges in managing patients with cloacal exstrophy. The Sections on Surgery and Otolaryngology will embark shortly on a joint policy statement on the management of children with hemangiomas and vascular malformations.

The Section on Surgery AAP Chapter liaisons are listed on page 9. Nearly all chapters now have a pediatric surgical representative whom they may call upon for advice about policy and legislative issues. On page 14 **Richard Ricketts**, a member of the Executive Committee and chapter liaison to District X, provides a commentary on this activity.

### Acknowledgement

I am honored to serve the membership as Chairperson of the Section. For six years on the Executive Committee I have had the privilege of working with many dedicated colleagues and friends, whose tireless work on behalf of the Section have resulted in a strong and vibrant organization. I thank the current members of the Executive Committee and planning committees (Program and Publications). The staff of the AAP has been challenged this year due to the sudden illness of our Section manager, **Chelsea Kirk**, whose absence since April 2005 has meant additional work for the administrative office. My deepest appreciation goes to Elizabeth McKay-Anaya for her diligence, competence, and determined expertise in keeping the Section afloat during a difficult period. To **Chelsea Kirk**, on behalf of the Executive Committee and the Section, I offer our sincere wishes for a full recovery and return to good health.

## Section on Plastic Surgery Program

**Session # H112**  
**Saturday, October 8, 2005**  
**9:00am – 4:45pm**  
**Bridge Room: Cabin John**  
**Grand Hyatt, Washington, DC**

9:00am  
**What's New in Vascular Anomalies**  
*John Mulliken, MD*  
Harvard Medical School

9:45am  
**The Hematologist's Role in Treating Vascular Lesions**  
*Denise Adams, MD*  
University of Cincinnati

10:30am  
**Interventional Radiology and Vascular Anomalies**  
*Patricia Burrows, MD*  
Harvard Medical School

11:15am  
**The Pediatric Surgeon's Role in Treatment of Vascular Anomalies**  
*Steven Fishman, MD*  
Harvard Medical School

12:00 noon – 1:30pm  
**Luncheon Meeting**

1:30pm  
**Laser and Cutaneous Treatment of Vascular Birthmarks**  
*Tina Alster, MD*  
Washington, DC

2:15pm  
**Surgical Management of Vascular Anomalies**  
*John Mulliken, MD*  
Harvard Medical School

3:00pm  
**Difficult Case? Ask the Experts**  
An interactive session between faculty and audience. Participants are encouraged to bring their own difficult cases to discuss.

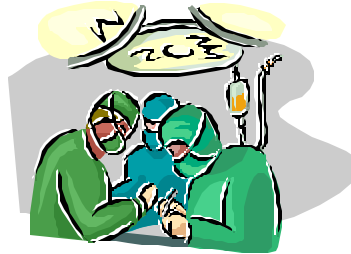
**Plastic Surgery Section Scientific Abstract Session**

3:30pm  
**Congenital Muscular Torticollis: A Treatment Algorithm Integrating Botulinum Toxin Type A**  
*Matthew R. Swelstad and Louis Morales, Jr.* Craniofacial Plastic Surgery, Primary Children's Medical Center, Salt Lake City, Utah

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## Section on Surgery 2005 National Conference Program

**Dr. Fred Ryckman** (Cincinnati, OH), Chair of the Program Committee, announced the Scientific Program for the Surgical Section meeting at this year's NCE in Washington, DC. The program begins at **1:00 pm on Friday, October 7, 2005**, with a session entitled, "New Concepts in Wound Healing and Burn Management", by **Timothy Crombleholme** (Cincinnati, OH), **David Greenhalgh** (Sacramento, CA) and **Steven Boyce** (Cincinnati, OH). This session is followed by the annual **Cancer Program**, moderated by **Fred Ryckman** (Cincinnati, OH). This year's area of focus is **Complex Surgical Management**. The faculty will include **Andrew Davidoff** (Memphis, TN), **Daniel von Allmen** (Chapel Hill, NC) and **Greg Tiao** (Cincinnati, OH).



The first scientific session begins at **7:30 am on Saturday, October 8** with the presentation of papers in competition for the **Rosenkrantz Resident Research Awards**. On **Saturday at 10:45 am**, the **William E. Ladd Medal** will be presented followed by our **Stephen L. Gans Distinguished Overseas Lecture**. The **Section Business Meeting** will be at **11:45 am**.

At **12:15 pm on Saturday**, there will be a luncheon allowing members to discuss with poster presenters their research in an open format following brief oral presentations by selected poster presenters. Included among these will be those posters being considered for the **Rosenkrantz Resident Research Awards**. From **2:00-5:00 pm on Saturday**, there will be a **Clinical Science Symposium on Gastroesophageal Reflux** by **George Holcomb, III** (Kansas City, MO), **Steven Rothenberg** (Denver, CO), **Ted Stathos** (Denver, CO) and **Jeffrey Ponsky** (Cleveland, OH).

Our **57<sup>th</sup> Annual Section Reception and Banquet** will be at **7:00 pm on Saturday** night at the Egyptian Embassy. ***BECAUSE OF THE UNIQUE LOCATION AND SECURITY CONCERNS AT THE EGYPTIAN EMBASSY, NO ON-SITE BANQUET TICKETS WILL BE AVAILABLE.*** This is a black-tie event and will include presentation of the **Rosenkrantz Resident Research Award winners**.

The Section educational session continues on **Sunday at 7:30 am** with additional presentations from the podium and concludes with the presentation of the **Arnold M. Salzberg Mentorship Award at 11:00 am**. This will be followed at **11:30 am** by the popular **Luncheon with Clinical Problem Solving Session**, hosted again this year by **Michael Caty** (Buffalo, NY) and **Sigmund Ein** (Toronto, Canada)

The Program Committee has labored extensively in carefully considering all of the submissions for this year's meeting and in organizing the joint sessions in an effort to provide the membership with an exciting and informative meeting. **We encourage you to attend and look forward to seeing you in Washington!**

See page 4 for a detailed breakdown of the three day program!

## Pediatric Surgery Residents' Conference

Indiana University JW Riley Hospital for children is hosting this year's 26th Annual Pediatric Surgery Residents' Conference. AAP Section on Surgery member Dr. Deborah Billmire has planned a wonderful program for the residents.

**Thursday, Oct 6 - Grand Hyatt**  
7:00-10:00 Reception and Dinner  
Welcome: Fred Rescorla  
Speaker: Jay L. Grosfeld  
***History of Pediatric Surgery***

**Friday, Oct 7 - Grand Hyatt**  
7:00-7:45 Continental Breakfast

7:45-8:00 Introduction: Fred Rescorla

8:00-9:30 ***What Your Mentor Has Never Told You***

8:00-8:20 Private Practice,  
Glaze Vaughn  
8:20-8:40 Clinical Academic  
Practice, David Carney  
8:40-9:00 Research Academic  
Practice, Cindy Gingalewski

9:00-9:30 Open Panel Discussion

9:30-9:45 Break

9:45-10:00 ***Surgical Section AAP***  
Robert Arensman

10:00-11:00 ***Interesting Cases from the Fellows***  
Moderator, Rescorla  
2 minutes/ 2 slides from each program

11:00-12:00 ***Clinic- There is No Escape***

11:00-11:20 Post op  
Hirschsprungs/ Imperforate  
Anus  
Karen West  
11:20-11:40 Chest Wall  
Deformity  
Scott Engum  
11:40-12:00 Clinic Potpourri  
Vaughn, Carney,  
Gingalewski, West, Engum

## Section on Surgery 2005 National Conference Program

### FRIDAY, OCTOBER 7, 2005

- 1:00pm – 3:00pm      **New Concepts in Wound Healing and Burn Management**
- 3:00pm – 5:00pm      **Cancer Program**  
Oncology Symposium – Complex Surgical Management

### SATURDAY, OCTOBER 8, 2005

- 7:30am – 9:00am      **Scientific Session 1 (Rosenkrantz Resident Research Award Presentations)**
- 9:00am -9:15pm      **Break**
- 9:15am-10:45am      **Scientific Session 2 (Rosenkrantz Resident Research Award Presentations)**
- 10:45 – 11:00 am      **Presentation of the William E. Ladd Medal**  
Patricia K. Donahoe, MD, FAAP  
Boston, MA
- 11:00am – 11:45am      **Stephen L. Gans Distinguished Overseas Lecture**  
*Quality Improvement in Pediatric Surgery: The Rotterdam Experience*  
Frans W. J. Hazebroek, MD, PhD  
Rotterdam, The Netherlands
- 11:45am – 12:15pm      **Section Business Meeting and Luncheon**
- 12:15pm – 2:00pm      **Rosenkrantz Resident Research Competition Poster Session and Luncheon**
- 2:00pm - 5:00pm      **Gastroesophageal Reflux – Clinical Science Symposium.**
- 7:00pm – 11:00pm      **57<sup>th</sup> Anniversary Reception and Banquet at the Egyptian Embassy**  
*(Advance Registration Required - no onsite tickets will be available this year due to security measures)*  
Presentation of Rosenkrantz Resident Research Awards

### SUNDAY, OCTOBER 9, 2006

- 7:30am – 9:00am      **Scientific Session 3**
- 9:00am-9:15am      **Break**
- 9:15am –11:00am      **Scientific Session 4**
- 11:00am – 11:15pm      **Presentation of the Arnold M. Salzberg Mentorship Award** *(Supported by an educational grant from Ethicon, Inc.)*  
J. Laurance Hill, MD  
Baltimore, MD
- 11:30am-1:30pm      **Luncheon Clinical Problem Solving Session**  
*(Advance registration required for lunch tickets)*

## Section on Urology Program

### Saturday, October 8, 2005

Session # H219  
Grand Hyatt, Independence A  
7:00am – 5:00pm

**Abstract sessions** throughout the day on: Kidney, Bladder, Vesicoureteral Reflux, Informatics, Genitalia, and Voiding Dysfunction. Plus, lectures and panel discussions on:

7:15am - 8:15am  
**Master Class-Instructional Review**  
The Emerging Role of MRI in Pediatric Urology

11:30am - 12:15pm  
**AAP Lattimer Lecture**  
Presenter: *Kim Wallen, Ph.D.*  
The Impact of Androgen on the Developing Brain

3:16pm – 5:00pm  
**Discussion Panel :**  
Timing of Genital Surgery in Children with Intersex

### Sunday, October 9, 2005

Session # H323  
Grand Hyatt, Independence A  
7:00am - 3:30pm

**Abstract sessions** throughout the day on: Hypospadias, Bladder, Laparoscopy, Kidney, and Vesicoureteral Reflux. Plus, lectures and panel discussions on:

7:00am - 8:15am  
**Video Forum: Techniques in Orchidopexy and Varicocelectomy**

11:00am - 11:45pm  
**AUA Lecture**  
Presenter: *Al Hunt*  
The Politics of Having Children with Special Needs

2:35pm – 3:20pm  
**Discussion Panel:**  
Management of Common Office Pediatric Urology Problems

### Monday, October 10, 2005

Session #H323  
Grand Hyatt, Independence A  
7:00am – 5:15pm

The Business of Urology. (No abstracts on Monday.)

8:00am -8:45am  
**EMR in Pediatric Urology: What's the ROI?**

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# Places to visit in Washington, DC

## 2005 AAP NATIONAL CONFERENCE AND EXHIBITION!

**Welcome to Washington, DC!** Explore the unique neighborhoods, visit the famous attractions, and discover the cultural and historical treasures that lie in and around America's capital city. The District is not only a government town. Washington, DC is a vibrant urban center filled with trendy shops, fabulous restaurants and endless entertainment. Your choice of world-class attractions has grown even more exciting in the past year with the opening of the National World War II Memorial, the National Museum of the American Indian and the Marian Koshland Science Museum. These new attractions join a lengthy list of "must-sees" in Washington, DC. From historic neighborhoods to national monuments and memorials, take the time to discover Washington, DC.



**Arlington National Cemetery**, our nation's most treasured burial ground, is home to more than 285,000 honored dead. Among the thousands of white headstones are the graves of President John F. Kennedy, Supreme Court Justice Thurgood Marshall, world champion boxer Joe Louis and the Tomb of the Unknowns. Veterans from all the nation's wars are buried in the cemetery, from the American Revolution through the Persian Gulf War and Somalia. Pre-Civil War dead were reinterred after 1900. The Tomb of the Unknowns is one of the more-visited sites at Arlington National Cemetery. It is guarded by the U.S. Army 24 hours a day, 365 days a year.



**The Lincoln Memorial** is a tribute to President Abraham Lincoln and the nation he fought to preserve during the Civil War (1861-1865). It was built to resemble a Greek temple. It has 36 Doric columns, one for each state at the time of Lincoln's death. A sculpture by Daniel Chester French of a seated Lincoln is in the center of the memorial chamber. Inscribed on the south wall of the monument is the Gettysburg Address. Above it is a mural painted by Jules Guerin depicting the angel of truth freeing a slave. Guerin also painted the unity of North and South mural on the north wall. Etched into the north wall below the mural is Lincoln's second inaugural speech.



**Smithsonian Institution** Known as the Castle, the oldest of the fourteen Smithsonian museums in Washington houses the crypt of founder James Smithson, 2 orientation theaters, scale models of Washington's monumental core, interactive touch-screen program in 6 languages, 2 electronic wall maps, plus multilingual information and assistance.

**Lafayette Square** is a seven-acre public park located directly north

of the White House on H Street between 15th and 17th Streets, NW. The Square was separated from the White House grounds in 1804 when President Jefferson had Pennsylvania Avenue cut through. In 1824, the Square was officially named in honor of General Lafayette of France. Lafayette Park has been used as a race track, a graveyard, a zoo, a slave market, an encampment for soldiers during the War of 1812, and many political protests and celebrations.



**57th Annual  
Section on Surgery  
Banquet**

**Saturday, October 8,, 2005  
7:00pm**

Location:  
**Egyptian Embassy,  
Washington DC**



*The Presentation of Rosenkrantz Resident Research Awards will take place at the banquet.*

**PLEASE NOTE: Tickets for this event must be purchased by September 2nd. Due to security, no on-site tickets will be available.**  
<http://www.aap.org/nce>

## 2005 Section Award Winners: To Be Presented in Washington, DC



**Ladd Medalist:** The William E. Ladd Medal represents the highest honor that the Section bestows on a physician, in recognition of outstanding contributions to the field of pediatric surgery. The Section on Surgery awards the 2005 Ladd Medal to **Dr. Patricia K. Donahoe**. In 1988 Dr. Donahoe was named the Marshall K. Bartlett Professor of Surgery at the Harvard Medical School, where she was named a Distinguished Scholar from 2003-2005. From 1991-2003 she served as the Chief of Pediatric Surgical Services at the Massachusetts General Hospital, Boston, Massachusetts. Dr. Donahoe is a world-renowned surgical scientist in the field of fetal biology and Mullerian inhibiting substance. She has received numerous professional awards in recognition of her basic science investigative work, including being named a Fellow of the American Academy of Arts and Sciences, a Fellow of the National Academy of Sciences, and a Fellow of the Institute of Medicine.



**Stephen L. Gans Distinguished International Lecturer:** The 2005 Stephen L. Gans Distinguished International Lecturer is **Professor Frans Hazebroek**, the Chief of the Department of Pediatric Surgery at the Sophia Children's Hospital and Professor of Pediatric Surgery at Erasmus University, Rotterdam, The Netherlands. Dr. Hazebroek is highly published in the areas of neonatal surgical anomalies, cryptorchidism and ambiguous genitalia, and medical ethics. He is a member of several professional organizations in pediatric surgery, including an honorary member of the American Pediatric Surgical Association. Dr. Hazebroek will address the Section on "Quality Improvement in Pediatric Surgery: The Rotterdam Experience".



**Arnold M. Salzberg Mentorship Award:** (supported by an education grant by Ethicon, Inc.) In 1997 the Section established an award in honor of Dr. Arnold Salzberg, who was a distinguished pediatric surgeon noted for his devotion to mentoring young physicians and future pediatric surgeons. The Section awards the 2005 Arnold M. Salzberg Mentorship Award to **Dr. J. Laurance Hill**. Dr. Hill served as Professor of Surgery at the University of Maryland School of Medicine and was the founder of the pediatric surgical service at the University of Maryland Hospital. At this institution he fostered the careers of many surgical residents, inspiring in them a desire to pursue pediatric surgery. Dr. Hill was the consummate technical surgeon, skilled in cardiothoracic and pediatric surgery, for whom no case proved too difficult or impossible. His devotion to superior patient care set the standard for all surgical residents at the University of Maryland.

## 2004 Section on Surgery Rosenkrantz Resident Research Award Winners

1<sup>st</sup> place 8 minute presentation: *Nicole Bernal, MD, Cincinnati, OH*  
Evidence for Active WNT Signaling During Postresection Intestinal Adaptation

2<sup>nd</sup> place 8-minute presentation: *Shawn Safford, MD, Durham, NC*  
A study of 11,013 Patients with Hypertrophic Pyloric Stenosis and the Association Between Surgeons and Hospital Volume Outcomes

1<sup>st</sup> place 3-minute presentation winner: *J. Brent Roaten, MD, Denver, CO*  
Survival in Sentinel Node Positive Pediatric Melanoma

2<sup>nd</sup> place 3-minute presentation winner: *Sean Barnett, MS, MD, Minneapolis, MN*  
Salmonella Typhimurium Invades and Decreases Tumor Burden in Neuroblastoma

1<sup>st</sup> place poster presentation: *Sonya Walker, MD, Pittsburgh, PA*  
Murine Neuroblastoma Attenuates Dendritic Cell CCR7 Expression

2<sup>nd</sup> place poster presentation: *Marybeth Browne, MD, Chicago, IL*  
Matrix Metalloproteinases Degrade Angiogenic Inhibitory Pigment Epithelium-Derived Factor (PEDF) Levels in Wilms Tumor



## Report of the Pediatric Surgery Board

by Keith Georgeson, MD

The Pediatric Surgery Board of the American Board of Surgery (PSB) was organized in January 2000 as a sub-board to the American Board of Surgery. The PSB helps the American Board of Surgery maintain pediatric surgical subspecialty certification. Current members of the Board of the PSB include Donna Caniano, MD, representing the AAP; Marshall Schwartz, MD and Keith Oldham, MD, representing APSA; Moritz Ziegler, MD representing the Pediatric Surgery Advisory Council of the American College of Surgeons and Keith Georgeson, MD representing the Pediatric Surgery Program Directors.

### At-Large Board Member

The Pediatric Surgery Board plans to add an at-large member beginning in July of 2006. Any American Board of Surgery certified pediatric surgeon may make nominations including self-nominations. The following criteria will be met by the nominees for the at-large board position:

Must be 10 years beyond completion of their pediatric surgical residency.

Must be established in active surgical practice and be highly regarded by surgical colleagues.

Must be currently certified in Pediatric Surgery by the ABS.

Must receive supporting letters from at least three pediatric surgeons certified by the ABS.

Must not come from the same practice group or city as a current member of the PSB.

Should add diversity to the current Board membership.

The application of letters of support must be submitted to the ABS office by no later than December 1, 2005. The PSB will select the at-large member from among the nominees submitted to them. The term is for six years. The travel and per diem expenses for this at-large board member will be covered completely. An

application packet will be sent to any requesting pediatric surgeon by contacting the ABS office. Our greatest current need on the Board is the addition of someone representing pediatric surgical private practitioners.

### Recertification Scores

There has been a discrepancy in failure rates between the 10 year recertification examination and the 20/30 year performance on the recertification examination. There is a 5-10% degradation in recertification board scores. The areas of most concern are critical care and general pediatrics. Perhaps maintenance of certification (MOC) requirements will narrow this gap in scores.

### Maintenance of Certification (MOC)

The American Board of Medical Specialties has adopted mandatory changes for maintenance of certification in all specialties and subspecialties. Pediatric surgeons must adhere to the mandated changes to maintain subspecialty certification. A maintenance of certification timeline is outlined for a pediatric surgeon who recertifies in the year 2005.

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## Dr Anderson to Lead ACS

The Section on Surgery extends its congratulations to **Dr. Kathryn Anderson**, elected President of the American

College of Surgeons. She assumes office in October 2005, becoming the first pediatric surgeon and the first woman to attain this honor.

**Dr. Anderson** was a member of the Executive Committee from 1980-1985 and Chairperson of the Section on Surgery in 1986.



## Section on Plastic Surgery Program

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3:40pm

**Tissue Adhesive Versus Subcuticular Closure After Excision of Angular Dermoid Cyst: A Prospective Analysis** *Denis A. Cozzi, Spagnol Lorna, Zani Augusto, Totonelli Giorgia, Di Battista Lorella and Francesco Cozzi.* Pediatric Surgery Unit, University of Rome La Sapienza, Rome, Italy

3:50pm

**Acute Ischemia of the Lower Extremity in the Neonate: A Protocol for Management**

*Peter J. Taub<sup>1</sup>, James P. O'Connell,<sup>2</sup> Aalok Singh<sup>3</sup>, Alan Pinto,<sup>3</sup> Matthew Kapklein,<sup>3</sup> Carey Goltzman<sup>3</sup>, and R. Michael Koch<sup>1</sup>.* Surgery, Division of Plastic Surgery<sup>1</sup>, Anesthesia,<sup>2</sup> and Critical Care,<sup>3</sup> Maria Fareri Children's Hospital, Valhalla, NY

4:00pm

**Nasal Deformity From Continuous Positive Airway Pressure (CPAP) – Classification and Treatment Protocol**

*David T.W. Chiu, Michael J. McLaughlin, and Jen-Tien Wung.* Columbia Presbyterian Medical Center, New York, NY

4:10pm

**Craniopagus Separation: Using The Past To Guide Recommendations For The Future**

*Matthew R Swelstad, and Louis Morales, Jr.* Craniofacial Plastic Surgery, Primary Children's Medical Center, Salt Lake City, Utah

4:20pm

**Hemangioma and Homeobox Gene Expression.**

*S.L. Hansen, W.Y. Hoffman, D.M.Young, and N.J. Boudreau.* Department of Surgery, Division of Plastic Surgery, University of California, San Francisco

4:30pm

**Abstract discussion/Q&A**

4:45pm

**Section Award Presentation**

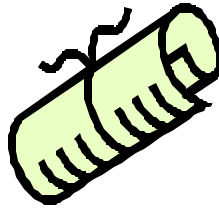
5:00pm

**Adjourn**

## Report of the Pediatric Surgery Board (continued from page 7)

### MOC Timeline for a PSB Diplomate Who Recertifies in 2005

<u>YEAR</u>	<u>MOC REQUIREMENT</u>
2005	Secure Recertification Examination
2006	Yearly CME
2007	Yearly CME
2008	Yearly CME, Self-assessment, Reference Letters
2009	Yearly CME
2010	Yearly CME, Practice Performance or Peer Review
2011	Yearly CME, Self-assessment, Reference Letters
2012	Yearly CME
2013-2015	Secure Recertification Examination



The holding of an unrestricted state license and peer reference letters will be used to indicate professionalism for the pediatric surgeon.

Life long learning will be demonstrated by completing 50 hours of continuing medical education per year with at least 30 hours in Category I. These Category I hours must be spent in topics specifically related to pediatric surgery.

Self-assessment will be available as a web-based examination on the American Board of Surgery website. One hundred to two hundred items will be available for this open book examination. Candidates must complete the answers to these questions on a three year cycle. Pediatric surgeons who fail to comply with this schedule must take the Pediatric Surgery Recertification Examination after five years to maintain their subspecialty certification.

Cognitive expertise will continue to be measured at ten year intervals using the secure Pediatric Surgery Recertification Examination.

Practice performance will be measured by documenting regular participation in at least one process where individual performance can be evaluated in the context of external norms or evidence based practice. Current examples include participation in a regional or national database such as the ECMO Registry or the Cancer/Oncology Group Registry. Another activity which will also apply will be active participation in a morbidity and mortality conference that targets practice improvement as one of its main goals. Attendance at a morbidity and mortality conference must occur at least once a month.

The Pediatric Surgery Board is anxious to serve pediatric surgeons and is open to any suggestions you have. Please e-mail your thoughts or suggestions to me at [keith.georgeson@ccc.uab.edu](mailto:keith.georgeson@ccc.uab.edu).

Keith Georgeson, MD, FAAP  
Chairman of the Pediatric Surgery Board

## Surgical Advisory Panel (SAP) Update

The SAP met with several AAP leaders May 1<sup>st</sup>, 2005 to discuss issues of membership value for Specialty Fellows. In addition to representatives from the surgical sections, anesthesiology and radiology were present. AAP leaders included Ed Bailey, MD, FAAP, (Chair of membership, ABCOM); Errol Alden, MD, FAAP, (CEO Executive Director, AAP), John Forbes MBA, (COO, AAP), Ken Slaw, PhD, (Director, Department of Membership, AAP). This was a highly productive meeting as we discussed what surgeons truly value in belonging to the AAP. Discussion also entailed looking at different annual dues structures and NCE fees to reflect Specialty Fellow interests and values. Some pilot initiatives are being developed for 2006 that will hopefully better address the interests of the Specialty Fellows.

The SAP made several suggestions to the National Conference and Exhibition Group to significantly improve the process of planning for the NCE educational programs that are proposed by the sections. Although there is some ongoing dialogue, these suggestions were largely rejected. The section program chairs and section chairs have, without fail, been frustrated by the current process when planning section and NCE educational programs. This will remain a major issue for the SAP in the upcoming years.

Dr. Kurt Newman was appointed as Surgical Section Liaison to the Task Force on Medical Devices. This is task force is exploring ways to increase the number of medical devices for pediatric use.

Finally, Dr. Michael Cunningham MD, FAAP is stepping down as Chair of the SAP. He has been a superb leader in his role as SAP chair during the past 3 years. An election will be held this August for his successor.

Richard G. Azizkhan MD, FAAP  
Section on Surgery SAP  
Representative

## Section on Surgery Chapter Liaisons

<u>ST</u>	<u>Dist</u>	<u>Last Name</u>	<u>First Name</u>	<u>City</u>	<u>Phone</u>	<u>E-mail</u>
AK	VIII	Jolley	Stephen	Anchorage	907/563-1588	Drsgj414@aol.com
AL	X	Georgeson	Keith	Birmingham	205/939-9688	keith.georgeson@ccc.uab.edu
AR	VII	Smith	Samuel	Little Rock	501/320-1447	smithsamuel@exchange.uams.edu
AZ	VIII	Greenfeld	Jonathan	Tucson	520/795-5338	
CA	IX - 1	Moss	Lawrence	Palo Alto	650/723-6439	larrymoss@yale.edu
CA	IX - 3	Saenz	Nicholas	San Diego	858/966-7711	nsaenz@chsd.org
CT	I	Weiss	Richard	Hartford	860/545-9520	rweiss@ccmckids.org
DE	III	Mattei	Peter	Wilmington	302/651-5888	pmattei@nemours.org
FL	X	Hebra	Andre	St. Petersburg	727/892-4109	hebra@pediatricsurgicalgroup.com
GA	X	Ricketts	Richard	Atlanta	404/982-9938	richard.ricketts@oz.ped.emory.edu
HI	VIII	Shim	Walton	Honolulu	808/947-2611	Childrensurgery@hotmail.com
IA	VI	Lawrence	John	Iowa City	319/354-6328	john-lawrence@uiowa.edu
IL	VI	Loeff	Deborah	Oak Lawn	708/346-4200	
IN	V	West	Karen	Indianapolis	317/274-4682	westkar@aol.com
KS	VI	Snyder	Charles	Overland Park	913/491-0880	
KY	IV	Fallat	Mary	Louisville	502/629-8638	mefall01@athena.louisville.edu
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MO	VI	Synder	Charles	Kansas City	913/491-0880	
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ND	VI	Bailey	Patrick	Sioux Falls	605/333-7197	pbailey@usd.edu
NE	VI	Raynor	Stephen	Omaha	402/354-7400	
NH	I	Latchaw	Laurie	Lebanon	603/569-1316	laurie.latchaw@hitchcock.org
NJ	III	Gandhi	Rajinder	Paramus	201/225-9440	
NJ*	III	Whalen	Tom	New Brunswick	732/235-7821	Whalen@vmonj.edu
NM	VIII	Hatch, Jr.	Edwin	Albuquerque	505/224-7482	Ehatch@phs.org
NV	VIII	Reyna	Troy	Las Vegas	702/650-2500	
NY	II-1	Nicolette	Linda	Syracuse	315/464-2878	nicolei@upstate.edu
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OK	VII	Tuggle	David	Oklahoma	405/271-5922	David-tuggle@ouhsc.edu
OR	VIII	Silen	Mark	Portland	503/494-7758	
PA	III	Mattei	Peter	Wilmington	302/651-5888	pmattei@nemours.org
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TX	VII	Lally	Kevin	Houston	713/500-7300	kevin.p.lally@uth.tmc.edu
VA	IV	McGahren,III	Eugene	Charlottesville	434/924-5643	edmgk@virginia.edu
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WI	VI	Lund	Dennis	Madison	608/263-9419	lund@Surgery.wisc.edu
WV	III	Beaver	Bonnie	Huntington	304/691-1200	Bbeaver@marshall.edu
Ontario - V		Kim	Peter	Toronto	416/813-6357	peter.kim@sickkids.on.ca
Puerto Rico -X		Ortiz-Justinlano	Victor	Mayaguez	787/763-0964	paponel@caribe.net

**To read about the experience of Dr. Ricketts as a chapter liaison, please see page 14.**

**Liaisons were assigned to their respective chapters in the order in which they volunteered. Due to a high response rate, a number of Chapters have alternate liaisons. For a complete listing of liaisons, including alternates, please visit the section website at [www.aap.org/sections/surgery](http://www.aap.org/sections/surgery).**

**If you are interested in serving as the liaison to your Chapter, please contact  
Chelsea Kirk at [ckirk@aap.org](mailto:ckirk@aap.org).**

## Notable Contributions by Section on Surgery Members to *Pediatrics*

During 2004 and 2005 members of the Section on Surgery published noteworthy articles in *Pediatrics*. The abstracts of their work are printed for your review.

### ***The Diagnosis of Appendicitis in Children: Outcomes of a Strategy Based on Pediatric Surgical Evaluation***

Ann M. Kosloske, MD, MPH, C. Lance Love, MD, James E. Rohrer, PhD, Jane F. Goldthorn, MD and Stuart R. Lacey, MD

**Objective:** To determine the accuracy of a protocol for diagnosis of appendicitis in children based on clinical evaluation by a pediatric surgeon with selective use of diagnostic imaging studies. We performed this study because 1) current reports in the medical, pediatric, emergency medical, and surgical literature advocate imaging, particularly computed tomography (CT), as the gold standard for diagnosis of appendicitis, and 2) the value of pediatric surgical evaluation early in the management of the child with possible appendicitis has rarely been emphasized.

**Methods, Design, Setting, and Participants:** Retrospective review of 356 children (mean age: 9.6 years; range: 1–18 years) referred to a regional pediatric surgical center for possible appendicitis from 1999 through 2001.

**Interventions:** Initial pediatric surgical evaluation consisted of history, physical examination, white blood cell count, differential count, and urinalysis. Children diagnosed with appendicitis underwent appendectomy without additional studies; those with equivocal findings received intravenous fluids, rest, and reevaluation after 4 to 6 hours. Imaging was used selectively by the pediatric surgeon.

**Outcome Measure:** Sensitivity, specificity, positive predictive value, negative predictive value, and accuracy of the protocol based on final diagnoses; rate of appendiceal perforation; and rate of negative

appendectomy.

**Results:** Of 356 children evaluated for appendicitis, 220 (62%) had an appendectomy. Two-hundred nine (95%) had histologically proven appendicitis, and 11 (5%) had a normal appendix. Of the 209 children with appendicitis, 139 (66%) had acute appendicitis, 34 (16%) had advanced appendicitis without perforation, and 36 (17%) had advanced appendicitis with perforation. Appendectomy was performed after initial evaluation in 195 (89%) of the 220 children and after a period of supportive care and observation in 25 (11%) of 220. One hundred thirty-six children (38%) did not have an appendectomy and were discharged with other diagnoses. The sensitivity of this protocol was 99%, specificity was 92%, positive predictive value was 95%, and negative predictive value was 99%. The accuracy was 97% compared with an accuracy of 82% for ultrasound alone and 90% for CT scan alone.

**Conclusions:** These data show that a protocol based on clinical evaluation by a pediatric surgeon with selective use of imaging was highly accurate for the diagnosis of appendicitis in children. Low rates of negative appendectomy (5%) and perforation (17%) were achieved without the potential costs and radiation exposure of excess imaging. **113:29-34, January 2004.**

### ***Does Pediatric Surgical Specialty Training Affect Outcome After Ramstedt Pyloromyotomy? A Population-Based Study***

Jacob C. Langer, MD and Teresa To, PhD

**Objective:** Ramstedt pyloromyotomy is a common operation in infants and is often done by general surgeons. We wished to determine whether there are any differences in outcome when this procedure is done by subspecialist pediatric general surgeons as compared with general surgeons.

**Methods:** All Ramstedt pyloromyotomies in the province of Ontario between 1993 and 2000 were reviewed.

Children with complex medical conditions or prematurity were excluded. Cases done by general surgeons were compared with those done by pediatric surgeons, specifically examining hospital stay and complications.

**Results:** Of 1777 eligible infants, 67.9% were operated on by pediatric surgeons and 32.1% by general surgeons. Total and postoperative lengths of stay were longer in the general surgeon group compared with the pediatric surgeons (4.31 vs 3.50 days for length of stay; 2.95 vs 2.25 days for postoperative length of stay). The general surgeons had a higher overall complication rate (4.18% vs 2.58%). The incidence of duodenal perforation among general surgeons was almost 4 times that of pediatric surgeons (relative risk: 3.65; 95% confidence interval: 1.43-9.32). Of the 4 infants who required repeat surgery because of an incomplete pyloromyotomy, all were originally operated on by a general surgeon. Analysis of the effect of surgeon volume on outcomes suggested that higher volume resulted in better outcome in both groups.

**Conclusion:** Subspecialist pediatric general surgeons achieve superior outcomes for children who undergo Ramstedt pyloromyotomy. **113:1342-1347, May 2004.**

### ***Bariatric Surgery for Severely Overweight Adolescents: Concerns and Recommendations***

Thomas H. Inge, MD, PhD, Nancy F. Krebs, MD, Victor F. Garcia, MD, Joseph A. Skelton, MD, Karen S. Guice, MD, Richard S. Strauss, MD, Craig T. Albanese, MD, Mary L. Brandt, MD, Lawrence D. Hammer, MD, Carol M. Harmon, MD, PhD, Timothy D. Kane, MD, William J. Klish, MD, Keith T. Oldham, MD, Colin D. Rudolph, MD, Michael A. Helmrath, MD, Edward Donovan, MD and Stephen R. Daniels, MD, PhD

As the prevalence of obesity and obesity-related disease among adolescents in the United States continues to increase, physicians are

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## Notable Contributions... (continued from page 10)

increasingly faced with the dilemma of determining the best treatment strategies for affected patients. This report offers an approach for the evaluation of adolescent patients' candidacy for bariatric surgery. In addition to anthropometric measurements and comorbidity assessments, a number of unique factors must be critically assessed among overweight youths. In an effort to reduce the risk of adverse medical and psychosocial outcomes and increase compliance and follow-up monitoring after bariatric surgery, principles of adolescent growth and development, the decisional capacity of the patient, family structure, and barriers to adherence must be considered. Consideration for bariatric surgery is generally warranted only when adolescents have experienced failure of greater than or equal to 6 months of organized weight loss attempts and have met certain anthropometric, medical, and psychologic criteria. Adolescent candidates for bariatric surgery should be very severely obese (defined by the World Health Organization as a body mass index of greater than or equal to 40), have attained a majority of skeletal maturity (generally greater than or equal to 13 years of age for girls and greater than or equal to 15 years of age for boys), and have comorbidities related to obesity that might be remedied with durable weight loss. Potential candidates for bariatric surgery should be referred to centers with multidisciplinary weight management teams that have expertise in meeting the unique needs of overweight adolescents. Surgery should be performed in institutions that are equipped to meet the tertiary care needs of severely obese patients and to collect long-term data on the clinical outcomes of these patients. **114: 217-223, July 2004.**

### ***Do-Not-Resuscitate Orders for Pediatric Patients Who Require Anesthesia and Surgery***

Mary E. Fallat, MD, Jayant K. Deshpande, MD

This clinical report addresses the

topic of preexisting do-not-resuscitate (DNR) orders for children undergoing anesthesia and surgery. Pertinent issues addressed include the rights of children, surrogate decision-making, the process of informed consent, and the roles of surgeons and anesthesiologists. The reevaluation process of DNR orders called "required reconsideration" can be incorporated into the process of informed consent for surgery and anesthesia. Care should be taken to distinguish between goal-directed and procedure-directed approaches to DNR orders. By giving parents or other surrogates and clinicians the option of deciding from among full resuscitation, limitations based on procedures, or limitations based on goals, the child's needs are individualized and better served. **114: 1686-1692, December 2004.**

### ***Trends in Operative Management of Pediatric Splenic Injury in a Regional Trauma System***

Daniela H. Davis, MD, MSCE, A. Russell Localio, JD, MS, Perry W. Stafford, MD, Mark A. Helfaer, MD and Dennis R. Durbin, MD, MSCE

**Objective:** Selective nonoperative management of pediatric blunt splenic injury became the standard of care in the late 1980s. The extent to which this practice has been adopted in both trauma centers and nontrauma hospitals has been investigated sporadically. Several studies have demonstrated significant variations in practice patterns; however, most published studies capture only a selective population over a relatively short time interval, often without simultaneous adjustment for confounding variables. The objective of this study was to characterize the variation in operative versus nonoperative management of blunt splenic injury in children in nontrauma hospitals and in trauma centers with varying resources for pediatric care within a regionalized trauma system in the past decade.

**Methods:** The study population included all children who were younger than 19 years and had a

diagnosis of blunt injury to the spleen (*International Classification of Diseases* code 865.00–865.09) and were admitted to each of the 175 acute care hospitals in Pennsylvania between 1991 and 2000. The proportion of patients who were treated operatively was stratified by trauma-level certification and adjusted for age and splenic injury severity. Multivariable logistic regression models were used to generate probabilities of splenectomy by age, injury severity, and hospital type.

**Result:** From 1991 through 2000 in Pennsylvania, 3245 children sustained blunt splenic injury that required hospitalization; 752 (23.2%) were treated operatively. Generally, as age and splenic injury severity increased, the proportion of patients who were treated operatively increased. Compared with pediatric trauma centers, the relative risk (with associated 95% confidence interval) of splenectomy was 4.4 (3.0–6.3) for level 1 trauma centers with additional qualifications in pediatrics; 6.2 (4.4–8.7) for level 1 trauma centers, 6.3 (5.3–7.4) for level 2 trauma centers, and 5.0 (4.2–5.9) for nontrauma centers. Significant variation in practice pattern was seen among hospital types and over time even after adjustment for age and injury severity.

**Conclusion:** The operative management of splenic injury in children varied significantly by hospital trauma status and over time during the past decade in Pennsylvania. Given the relative benefits of nonoperative treatment for children with blunt splenic injury, these results highlight the need for more widespread and standardized adoption of this treatment, particularly in hospitals without a large volume of pediatric trauma patients. **115: 89-94, January 2005.**

### ***Use of Cholecystokinin-Octapeptide for the Prevention of Parenteral Nutrition-Associated Cholestasis***

Daniel H. Teitelbaum, MD, Thomas F. Tracy, Jr, MD, Moustafa M. Aouthmany, MD, Adolfo Llanos, MD, Morton B. Brown, PhD, Sunkyung Yu, MS, Marilyn R. Brown, MD, Robert J. Shulman, MD, Ronald B. Hirschl, MD,

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## Notable Contributions...(continued from page 11)

Patricia A. Derusso, MD, Jeanne Cox, MS, Jacqueline Dahlgren, MS, MD, Jonathan I. Groner, MD and Peter J. Strouse, MD

**Objective:** To determine whether cholecystokinin-octapeptide (CCK-OP) would prevent or ameliorate parenteral nutrition-associated cholestasis (PNAC) among high-risk neonates treated with total parenteral nutrition.

**Study Design:** This was a multicenter, double-blind, randomized, controlled trial conducted between 1996 and 2001.

**Patients:** Neonates at risk for the development of PNAC included very low birth weight neonates and those with major surgical conditions involving the gastrointestinal tract.  
**Setting:** Tertiary care hospitals.

**Intervention:** Patients were randomized to receive CCK-OP (0.04 µg/kg per dose, twice daily) or placebo. Eligible infants were all <30 days of age. Patients were enrolled within 2 weeks after birth or within 7 days after surgery.

**Outcome Measures:** The primary outcome measure was conjugated bilirubin (CB) levels, which were measured weekly. Secondary outcome measures included incidence of sepsis, times to achieve 50% and 100% of energy intake through the enteral route, number of ICU and hospital days, mortality rate, and incidences of biliary sludge and cholelithiasis.

**Result:** A total of 243 neonates were enrolled in the study. CCK-OP administration did not significantly affect CB levels ( $1.76 \pm 3.14$  and  $1.93 \pm 3.31$  mg/dL for CCK-OP and placebo groups, respectively; mean  $\pm$  SD). Secondary outcome measures also were not significantly affected by the study drug.

**Conclusions:** Use of CCK-OP failed to reduce significantly the incidence of PNAC or levels of CB. CCK-OP had no effect on other secondary mea-

asures and should not be recommended for the prevention of PNAC. **115: 1332-1340, May 2005.**

### **Primary Operative Versus Nonoperative Therapy for Pediatric Empyema: A Meta-analysis**

Jeffrey R. Avansino, MD, Bryan Goldman, MS, Robert S. Sawin, MD and David R. Flum, MD, MPH

**Objective:** The optimal treatment of children with empyema remains controversial. The purpose of this review was to compare reported results of nonoperative and primary operative therapy for the treatment of pediatric empyema.

**Methods:** A systematic comprehensive review of the scientific literature was conducted with the PubMed (National Library of Medicine) database for the period from 1981 to 2004. This reproducible search identified all publications dealing with treatment of empyema in the pediatric population (less than 18 years of age). A meta-analysis was performed with studies with adequate data summaries for greater than or equal to 1 of the outcomes of interest for both treatment groups.

**Results:** Sixty-seven studies were reviewed. Data were aggregated from reports of children initially treated nonoperatively (3418 cases from 54 studies) and of children treated with a primary operative approach (363 cases from 25 studies). The populations were similar in age. Patients who underwent primary operative therapy had a lower aggregate in-hospital mortality rate (0% vs 3.3%), reintervention rate (2.5% vs 23.5%), length of stay (10.8 vs 20.0 days), duration of tube thoracostomy (4.4 vs 10.6 days), and duration of antibiotic therapy (12.8 vs 21.3 days), compared with patients who underwent nonoperative therapy. In 8 studies for which meta-analysis was possible, patients who received primary operative therapy were found to have a pooled relative risk of failure of 0.09, compared with those who did not. Meta-analysis could not be performed for any of the other outcome measures

investigated in this review. Similar complication rates were observed for the 2 groups (5% vs 5.6%).

**Conclusions:** These aggregate results suggest that primary operative therapy is associated with a lower in-hospital mortality rate, reintervention rate, length of stay, time with tube thoracostomy, and time of antibiotic therapy, compared with nonoperative treatment. The meta-analysis demonstrates a significantly reduced relative risk of failure among patients treated operatively. **115: 1652-1659, June 2005.**

## PEDIATRICS

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## Section on Urology Program

(continued from page 4)

8:45am - 9:30am

### **Making the Office Work**

**For You: Ultrasound, Mid-levels, Biofeedback....**

9:30am - 10:00am

### **Getting in Bed With Cor**

**porate America: Are Sponsored Clinical Trials Worth It?**

10:30am - 11:15am

### **Negotiating to Yes with Third Party Payers**

11:15am - 11:45am

### **Teaming Up With Your**

**Institution: The Stark Realities**

1:15pm - 2:00pm

### **The Financial Rewards of Having a Clinical Nurse Specialist in the Pediatric Urology Office**

2:00pm - 3:30pm

### **Billing and Coding in Pediatric Urology**

View the complete Section on Urology scientific program schedule at [www.aap.org/sections/urology/](http://www.aap.org/sections/urology/)

## 2004 Meeting Report

The Section on Surgery Program at the 2004 NCE was quite successful. The late Dr. Arvin Phillipart of Arizona was honored with the Salzberg Award and Dr. Daniel Hays of California received the Ladd Medal. The Stephen L. Gans Distinguished Overseas Guest Lecturer was Dr. Simon Kenny of Liverpool, England. His lecture, *Stem Cell Therapy for Hirschsprungs Disease*, was well received. A special thanks to Dr. Stuart Lacey of Arizona for putting together an excellent program. Please see pages 3-4 for details of the 2005 program.

## New Section on Surgery Members

July 2004-June 2005

### Specialty Fellows

John Judson Aiken MD, FAAP  
Douglas Clyde Barnhart MD, FAAP  
Elizabeth Beierle MD, FAAP  
Scott Charles Boulanger MD, FAAP  
Joseph Gibson Bussey III MD, FAAP  
Marilyn West Butler MD, FAAP  
A Alfred Chahine MD, FAAP  
Catherine Chia-Chi Chen MD, FAAP  
Dario De Oliveira Fauza MD, FAAP  
David S. Foley MD, FAAP  
Richard Glick MD, FAAP  
Andrea Anita Hayes-Jordan MD, FAAP  
Saleem Islam MD, FAAP  
Douglas Andrew Katz MD, FAAP  
Joseph E. Kelley Jr. MD, FAAP  
Heung Bae Kim MD, FAAP  
Stephen S. Kim MD, FAAP  
Alan Preston Ladd MD, FAAP  
Kewal Krishan Maudar MD, FRCS, FACS, PhD, MBBS  
Benedict Nwomeh MD, FAAP  
Mitchell R. Price MD, FAAP  
Carmen Teresa Ramos MD, FAAP  
Kirk Reichard MD, FAAP  
Henry E Rice MD, FAAP  
Cathy E. Shin MD, FAAP  
Oliver S. Soldes MD, FAAP  
Karl Gerard Sylvester MD, FAAP  
Evans Pierre Valerie MD, FAAP  
Garret S. Zallen MD, FAAP



## Meet the Subcommittee Members



### Section on Surgery Nominating Committee

#### Chairperson

**Thomas Weber, MD, FAAP**  
St. Louis, MO

**Frederick Rescorla MD, FAAP**  
Indianapolis, IN

**Mary Brandt, MD, FAAP**  
Houston, TX

### Section on Surgery Scientific Program Committee

#### Chairperson

**Frederick Ryckman, MD, FAAP**  
Cincinnati, OH

**Robert Kelly Jr., MD, FAAP**  
Norfolk, VA

**Michael Klein, MD, FAAP**  
Detroit, MI

#### Chairperson-Elect

**George Holcomb III, MD, FAAP**  
Kansas City, MO

**Arlet Kurkchubasche, MD, FAAP**  
Providence, RI

**Martin L. Blakely, MD, FAAP**  
Memphis, TN

**R. Lawrence Moss, MD, FAAP**  
New Haven, CT

**Andrew Davidoff, MD, FAAP**  
Memphis, TN

**Jed G. Nuchtern, MD, FAAP**  
Houston, TX

**Diana Farmer, MD, FAAP**  
San Francisco, CA

**Charles Smith, MD, FAAP**  
Charleston, SC

**Martin Keller, MD, FAAP**  
St. Louis, MO

**Jay M. Wilson, MD, FAAP**  
Kansas City, Kansas

### Section on Surgery Publications Committee

#### Chairperson

**Michael Skinner, MD, FAAP**  
Durham, NC

**Walter Chwals, MD, FAAP**  
Cleveland, OH

#### Chairperson-Elect

**John Gosche, MD, FAAP**  
Jackson, MS

**Steven Fishman, MD, FAAP**  
Boston, MA

**Marjorie Arca, MD, FAAP**  
Milwaukee, WI

**David A. Rodeberg MD, FAAP**  
Rochester, MN

**Daniel Beals, MD, FAAP**  
Lexington, KY

**Nicholas Saenz, MD, FACS, FAAP**  
San Diego, CA

**Terry Buchmiller, MD, FAAP**  
Boston, MA

**Karl Sylvester, MD, FAAP**  
Stanford, CA

**Dai Hyun Chung, MD**  
Galveston, Texas

**James R. Upp, Jr., MD, FAAP**  
Baton Rouge, LA

## Going to the Dance is Nice, but Getting Invited into the Home May be Better

by Richard Ricketts, MD, FAAP

The American Academy of Pediatrics was the first organization to recognize Pediatric Surgery as a distinct specialty when it invited us to join the organization, establish the Surgical Section of the AAP, and attend the Annual meeting (“the dance”) in 1948. The American College of Surgeons did not recognize pediatric surgery as a bonafide specialty until 1967 and the American Pediatric Surgical Association was not founded until 1970 (1). Through the many years of our association with the AAP, and thanks to the efforts from the great leadership from our Section, we have now arrived at a point where we have been invited to participate in the activities of the local chapters (“the home”) of the AAP. In 2000, members of the Council on Sections Management Committee (COSMAN) met with chapter representatives to discuss ways to facilitate collaboration between the Sections (in our case the Surgical Section) and the local chapters. COSMAN has asked our Section to designate an individual to serve as the surgical liaison (“contact person”) for each chapter of the AAP. I was appointed the surgical liaison to the Georgia Chapter of the AAP in January 2002. As I see it, the role of the surgical liaison is to bring our concerns “down” to the pediatricians at the local level – the persons upon whom we rely for our livelihood – and to bring their concerns “up” to the leadership of our section. My experience with the Georgia chapter of the AAP has been a very positive one and one which I believe will benefit pediatric surgery in Georgia as a whole.

The GA Chapter meets twice per year – once at the Cloister on Sea Island (not a bad place to have to go!), and once in Atlanta (easy for me to get to) – and the Board of Directors of the GA Chapter, of which I am now a member, meets one additional time per year in Atlanta. It is certainly not

an onerous task for me to attend one or two of these meetings a year. The Board has been very receptive to my participation in their meetings. I have gotten to know the leaders of the “pediatric community” in Georgia and they have gained a better understanding of some of the surgical issues with which they deal by interacting with me.

At the first meeting I attended (on Sea Island, no less!), I introduced and sought the local Board’s endorsement of the “Guidelines for Referral to Pediatric Surgical Specialists”. At that time, the Guidelines had been accepted by the AAP Board of Directors but had not been disseminated to the local chapters and had not yet been published in *Pediatrics*. (That came in July, 2002) (2). It was rewarding to get an overwhelming support of the Guidelines and unanimous endorsement for them, even from representatives from rural areas in Georgia where surgical subspecialists may not be found. The local pediatricians felt that the Guidelines could help them justify referral to surgical specialists when insurance companies discouraged such referrals. They felt that the AAP Board of Directors acted in the best interest of the child by adopting the Guidelines.

Subsequent to the Board meeting, all members of the GA Chapter of the AAP were notified of the endorsement by the local Board by the chapter’s “Blast Fax” mechanism. In addition, I was invited to and did write an article for *The Georgia Pediatrician* (3) explaining the Guidelines to all the pediatricians in the state.

One member of the Board of Directors suggested that I present the Guidelines to all the insurance companies covering pediatric patients in Georgia. Rick Ward, the Executive Director of the GA Chapter, and I met with the Medical Directors of the Georgia Association of Health Plans this spring to present the Guidelines to

them and to seek their endorsement. They listened, but they did not endorse the Guidelines (as would be expected!). But, we have made some inroads and we are now working on a response to their criticisms of the Guidelines and hopefully in the future, we will get their endorsement. None of this would have been possible without my association with the GA Chapter as its surgical liaison.

This represents just one example of successful collaboration between our Section and the local AAP chapter in Georgia. Other items of interest to surgeons which have been discussed at the local Board meetings that I have attended include the development of an anti-shaken baby program, treatment of childhood obesity, suggested surgical topics for the NCE, malpractice premiums, empty positions on some of the national AAP Committees, injury prevention programs, local legislative issues, etc.

I believe that the Surgical Liaison program can be a very successful mechanism for surgeons and pediatricians to interact on a local level to improve the care of children not only locally but nationally as well. The “top-down” (national surgical issues taken to local pediatricians) and the “bottom-up” (concerns of local pediatricians taken to our national Section) approach should ultimately benefit all children. While we’ve had some fun at “the dance”, we may be more effective in “the home”.

### References

1. Fonkalsrud EW: Pediatric Surgery Advances into the University Hospital. *J Pediatr Surg* 36:409-415, 2001.
2. *Pediatrics* 110:187-191, 2002.
- Ricketts RR: Guidelines for Referral to Pediatric Surgical Specialists. *The Georgia Pediatrician* 11:13, 2002.

## Spring 2005 Federal Legislative Report

### Access to Care: Legislative Outlook

The 109<sup>th</sup> Congress was convened in January. The Academy named access to care as its top priority for Congress and will be leading the fight to secure access to quality health care coverage for every child and adolescent. The Academy has already endorsed four bills that would expand access for children. Each of the bills would do a number of different things from insuring more children to the creation of a Medicaid commission. Concerned about recent pressure to cut entitlement programs like Medicaid, the Academy feels it is critically important to gain support for legislation that will expand access not hinder it. The Academy is working hard to gain additional attention and support for the bills in the coming months.

“We know that providing access to care for every child can help to prevent obesity, heart disease and diabetes,” said AAP President Carol Berkowitz, MD, FAAP. “This is why we are urging Congress to come together and work in a bipartisan way to help solve these problems.”

The four bills that have been endorsed by the Academy to date are:

- **Kids Come First Act of 2005**
- **Start Healthy, Stay Healthy Act of 2005**
- **Bipartisan Commission on Medicaid and the Medically Underserved Act of 2005**
- **Children’s Express Lane to Health Care Coverage Act of 2005**

### Insuring every child (Kids Come First and MediKids)

The Academy endorsed the *Kids Come First* (S. 114) bill, introduced by Sen. John Kerry (D-MA) for the first time in January, which would expand access to quality care for every child under age 21. The bill differs from the Academy’s MediKids proposal because it would still remain an option for the states to choose while MediKids is a guarantee.

The Academy has endorsed the *Kids Come First* bill and will continue to support the MediKids bill when it is introduced. The two bills complement each other and are not competing against each other. At press time, the MediKids bill was still being drafted. Look to future *AAP News* editions for further updates.

The *Kids Come First* bill was introduced to get states to expand Medicaid coverage for children, get parents to share in the responsibility of covering their children and eliminate enrollment barriers that prevent eligible children from signing up. In this bill, the federal government pays for all Medicaid outreach and coverage costs for children younger than age 21 with incomes at or below poverty level. In exchange, the states agree to pay for its share of a State Children’s Health Insurance Program (SCHIP) or Medicaid coverage expansion to children younger than age 21 whose incomes are under 300 percent of the poverty level. Lastly, the bill requires parents to insure all children younger than age 19 and requires proof of their coverage to avoid forfeiting their federal child tax exemption.

### Start Healthy, Stay Healthy

At press time, the bill was awaiting introduction by Sen. Jeff Bingaman (D-NM) and Richard Lugar (R-IN). This bipartisan legislation would significantly reduce the number of uninsured pregnant women and newborns by expanding coverage to pregnant women through the Medicaid and SCHIP programs. The bill would provide states the option to further extend coverage to continuously enroll newborns from birth through the first full year of life.

### Medicaid Commission

Sen. Gordon Smith (R-OR) and Sen. Jeff Bingaman (D-NM) introduced a bill calling for the creation of a Bipartisan Commission on Medicaid and the Medically Underserved (S. 338/H.R. 985). A companion House bill was introduced by Rep. Heather Wilson (R-NM). Sens. Smith and Bingaman believe that the Medicaid program

should undergo a comprehensive and thorough review of what is and is not working and how to improve service delivery and quality in the most cost-effective way possible. A similar review was conducted on Medicare, after it was called for in the Balanced Budget Act of 1997. Many senators have signed on to cosponsor the legislation in response to the president’s budget proposal inclusion of \$60 billion in Medicaid cuts. Those who have signed on stated that before any cuts are made to Medicaid, a thorough review of the program should be conducted.

### Children’s Express Lane

At press time, this bill was awaiting introduction by Sens. Bingaman and Lugar and would give states greater flexibility in the ways they can enroll uninsured children into Medicaid and SCHIP programs, while at the same time increasing government efficiency. The bill would give states the option of establishing that their Medicaid or SCHIP financial eligibility rules are satisfied when a family presents proof that their child is already enrolled in another public program with comparable income guidelines.

Efforts to expand access to care will continue throughout the congressional session. The Academy plans to support other access bills such as the Family Opportunity Act, which would expand Medicaid coverage to families with children with special health care needs and MediKids, the Academy’s proposal to insure every child.

AAP members should look to *AAP News*, the Federal Advocacy Action Network (FAAN)’s email action alerts and the AAP Member Center ([www.aap.org/moc](http://www.aap.org/moc), click on Federal Affairs) for legislative updates throughout the second session for information on when pediatricians should take action. For more information on AAP efforts to provide greater access to care, the AAP Department of Federal Affairs, (800) 336-5475, ext. 3001.

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The 2005 Executive Committee and Planning Committee Chairpersons: Sitting (left to right) Richard Azizkhan, Donna Caniano, Michael Klein; Standing in front row (left to right) Brad Warner, Kurt Newman, Richard Ricketts, Chelsea Kirk, Kevin Lally, and Whit Holcomb; Standing in back row (left to right) Michael Skinner and Fred Ryckman. Photograph taken at the March 2005 Executive Committee meeting, Chicago, Illinois.

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