



Spring 2001

American Academy of Pediatrics

# Transport Dispatch

Official Newsletter of the AAP Section on Transport Medicine

## "Pearls & Pitfalls"

"Pearls and Pitfalls" is a feature we hope to run in each edition of *Transport Dispatch*.

This feature will include alternating topics on neonatal and pediatric areas of interest.

*This issue's feature: Page 4*

## Chairman's Corner

It is a great honor for me to take over as Chair of our section. At the June 2000 Transport Conference, I introduced myself to the members who joined us at the Leadership Conference. At that time, I proposed that transport medicine had evolved to a high degree of sophistication in the United States and Canada, yet along with many of you who travel throughout the world, we notice that there is a paucity of services available for critically ill infants and children. The infant and child mortality rates may be as high as 30-40% in many countries that would be considered developed.

As I promised at that meeting, and also when I assumed the Chairmanship of the section, I would devote a large portion of my time in developing an International Neonatal/Pediatric Transport Committee. This committee would be responsible to set up the basic fundamentals of education, skills, training, and basic equipment for the development and implementation of a specialty neonatal/pediatric transport team. The members would benefit from the support of various pediatric organizations, thereby, providing the greatest talent both in the medical and nursing disciplines. We have the support of the Academy, through Dr. Errol Alden, Deputy Executive Director, as well as a proposal from Dr. Geoffrey Barker, President of the World Federation of Pediatric Critical Care, to establish this international committee as an official subcommittee of the World Federation.

The timeline to establish these educational guidelines would be approximately 2 ½ years, and a final manuscript will be published in the official journal of the World Federation of Pediatric Critical Care Medicine at the World Congress in 2003. I have already discussed with colleagues from the Far East, Europe, and Latin America and have received their overwhelming support from their respective pediatric organizations.

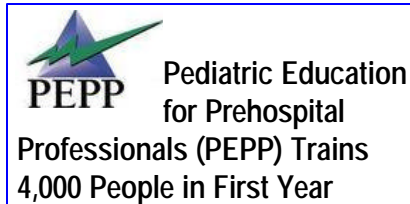
The committee makeup will be multidisciplinary, including physicians, nurses, and respiratory care practitioners. I will continue to keep the membership of our section informed as to the evolution and development of the International Committee.

On another note, the Section on Transport Medicine Executive Committee met in October at the AAP Annual Meeting in Chicago. A very important topic to all of us, that was discussed at that meeting, was the development of a database for patients who are transported between institutions. Dr. Alvin Hackel and Dr. Chung presented a tentative proposal to develop a database with a private company in California. Dr. Robert Insoft has been spearheading this project and will be giving us an updated report of the database in the late spring or early summer. We are also planning the annual meeting which will be held in San Francisco, as well as our transport conference, which, due to changes in the makeup of the conferences held by the Academy, we will be holding the conference during the annual meeting in Boston in 2002.

*continued on page 5*

## IN THIS ISSUE:

	<u>Page</u>
SOTM Executive Summary	3
Pearls & Pitfalls	4
Section on Critical Care Executive Committee Executive Summary	7
Section on Emergency Medicine Executive Committee Executive Summary	8
AAP Annual Meeting Information	9
Roster	10



## Pediatric Education for Prehospital Professionals: First of a Kind for Front Line Providers

*Carolyn Nieman RN, CEN -Flight Nurse, Metro Life Flight – Cleveland, Ohio*

In March of 2000 the Academy released Pediatric Education for Prehospital Professionals (PEPP), a continuing education program for Emergency Medical Technicians (EMTs) and Paramedics. The Academy arranged for 400 people at 8 sites around the country to be trained as official PEPP Course Coordinators. The first of these "rollouts" was held at the Emergency Medical Services for Children (EMSC) Congress last March. Those Course Coordinators went on to conduct PEPP courses around the country, and only one year later, more than 4,000 people have been trained in pediatric life-saving skills.

The PEPP program has an eight-hour basic life support (BLS) course and a 16-hour advanced life support (ALS) course. BLS courses teach attendees about applying the pediatric assessment triangle, respiratory emergencies, trauma and child maltreatment. In addition, hands-on sessions provide attendees with experience in the use of pediatric oral and nasopharyngeal airways, bag-valve mask ventilation and spinal immobilization.

ALS courses cover the same topics as those taught in BLS courses plus cardiovascular and medical emergencies, emergency delivery and newborn stabilization, and children with special health care needs. In addition to those areas taught in BLS interactive sessions, ALS sessions also provide attendees with experience in endotracheal intubation, foreign body removal and tracheostomy management, among others.

The PEPP steering committee is comprised of physician, nurse and paramedic representatives from the Academy, the American College of Emergency Physicians, Emergency Nurses Association, International Association of Fire Chiefs, International Association of Fire Fighters, National Association of Emergency Medical Services Educators, National Association of State EMS Directors and the National Association of EMS Physicians.

To find a PEPP course near you or for more information on implementing PEPP in your community, visit the PEPP Web site at [www.PEPPsite.com](http://www.PEPPsite.com) or send an e-mail message to [pepp@aap.org](mailto:pepp@aap.org).

Pediatric Education for Prehospital Professionals (PEPP), a program developed by the American Academy of Pediatrics, has been brought to northeast Ohio by the staff of Metro Life Flight. This unique program, designed specifically for prehospital providers, is a combination of descriptive educational videos, didactic lectures, small group scenarios, facilitated discussion groups and skill stations.

The PEPP program allows the provider to experience the wide spectrum of clinical findings that the compromised child can present with. The unique design of the program, coupled with the experience of caring for children by the staff of Metro Life Flight, is a great educational opportunity for both the seasoned and novice prehospital provider. Being a Course Coordinator and the Facilitator of Program Development I feel it's a natural fit for Metro Life Flight to bring forth this program. At Metro Life Flight we continue to build on an excellent tradition in caring for critically ill and injured children. Through dissemination of this new and exciting PEPP Course we hope to positively impact on the care critically ill children receive in Northeast Ohio.

MetroHealth Medical Center has a long history of caring for critically ill and injured children. MetroHealth is an academic health care and research facility affiliated with the Case Western Reserve University Schools of Medicine and Nursing. MetroHealth is also a Level One Trauma Center with Pediatric

Commitment, a Regional Spinal Cord Injury Center and a Regional Burn Center.

Metro Life Flight has established itself as a premier provider of prehospital education in both the academic and technical arenas. The PEPP course is offered in both basic and advanced formats to encompass all levels of EMS certifications. The PEPP program focuses more on the physiology of pediatric critical illness and less on disease-specific states. This is an important distinction in the pediatric population, because while a specific diagnosis may elude the EMS provider, certain common physiologic abnormalities require instant attention if outcomes are to be improved. Further, the PEPP program illustrates the importance of understanding children at various stages of development and enhances the ability of the EMS provider to perform an accurate assessment. This assessment is based on the global presentation of the patient and not solely based on the use of monitoring devices. PEPP closes the gap in pediatric EMS education and establishes a solid foundation of knowledge to initiate therapeutic intervention and assess intended effects. We at Cleveland Metro Life Flight are proud to present a program that will improve the outcome of ill and injured children.



## SECTION ON TRANSPORT MEDICINE EXECUTIVE COMMITTEE EXECUTIVE SUMMARY OCTOBER, 2000

The Executive Committee of the AAP Section on Transport Medicine (SOTM) met in conjunction with the 2000 Annual Meeting on October 29, 2000 in Chicago, Illinois. The following is a summary of the Section's activities and initiatives discussed during that meeting:

- The Executive Committee expressed interest in perhaps awarding two \$5000 research grants per year to individuals interested in transport medicine research.
- Dr. Brent King, Dr. C. Robert Chambliss, and Dr. Monica Kleinman were elected to their first three-year terms as Section Executive Committee members.
- Ms. Mucha asked the Department of Membership to reduce SOTM affiliate dues from \$85 to \$60, however, the first cycle of invoices were already mailed to AAP members. Subsequently, all SOTM affiliates went sent a letter explaining the reduction and telling affiliates that if they already paid the full \$85 amount, the SOTM would be reimburse them the \$25 difference.
- The SOTM sponsored a Section program at the 2000 Annual Meeting on Sunday, October 29, 2000 that included a business meeting and lunch. Discussions on the topics of pediatric international transport, developing a fully integrated patient access system and clinical and systematic approach to transport of the pediatric trauma patient were given as well as abstract presentations.

- Dr. Insoft is proposing a Section Program for the 2001 National Conference and Exhibition to include didactic sessions, abstract presentations, a panel discussion on team configuration, updates on legal issues surrounding transport medicine and presentation of clinical research topics.
- Ms. Mucha informed the Committee that 856 copies of the second edition of the *Guidelines for Air and Ground Transport of Neonatal and Pediatric Patients* had been sold as of September 2000.
- The final attendance count for the June 2000 CME course was 167 attendees in addition to 15 faculty. The final attendance count for the leadership course was 74 in addition to 10 faculty.
- The SOTM expressed concern that due to staff constraints and a limited number of "slots" for CME courses, their proposal to hold another course in 2002 may not be accepted. The Executive Committee was encouraged to submit an application for a 2002 course, however, there exists the possibility that it may not be accepted. The committee was assured that all applications would be given the same consideration before the Committee on CME makes their final decision.
- CME staff explained that the growing demand for Section educational needs is being recognized and an ad hoc group, comprised of staff and Section member representation, has been developed. The Committee agreed to submit their application for a 2002

course, but emphasized that they were very willing to explore other options including coupling with another group or holding the course at the 2002 National Conference and Exhibition in Boston.

- A respiratory therapist attended the meeting to discuss ways the SOTM could strengthen their relationship with respiratory therapists. It was thought that a closer, more synergistic relationship between transport medicine physicians and respiratory therapists would help co-educate the groups. Additionally, a liaison relationship such as this would allow the SOTM to utilize respiratory therapists as a resource in terms of transport issues, as well as to help market upcoming courses and SOTM sponsored events.
- The Winter 2000 edition of the Transport Dispatch newsletter was printed in color and on high-quality paper. The Executive Committee was very pleased with the new format but was aware that producing the newsletter in such a way could be quite expensive. It was decided the next newsletter would be done on-line with a mailing to the members announcing the website and asking their preference of either the paper or on-line version of the newsletter.
- The LISTSERV® continues to be an effective communication tool for SOTM members and AAP staff. Ms. Mucha urged the Executive Committee to send announcements, questions, and other messages

*continued on page 5*

# Pearls and Pitfalls

## Identification and Management of Ductal Dependant Cardiac Lesions in the Transport Setting

– Robyn Funk, BSN RN PHRN

Despite the availability of technology used to determine congenital defects in utero, we still find ourselves faced with the dilemma of unknown cardiac anomalies in newborns. For example, an infant who had no prenatal care or a normal prenatal ultrasound and is now presenting with signs and symptoms such as cyanosis, respiratory distress, murmur, progressive acidosis, and hypotension should have cardiac as a differential diagnosis. These symptoms can fit both persistent pulmonary hypertension of the newborn (PPHN) and critical congenital ductal dependent lesions of the heart (TGA w/IVS, HLHS, IAA, CoA, AS, TOF w/PA, PA w/IVS, and Ebstein's anomaly). A cardiac source must be considered, but pediatric ECHO technology or the means of interpreting the data may not be available at the referring hospital.

**Pitfalls:** The major pitfalls occur because each diagnosis needs to be treated and managed differently. The wrong approach could be detrimental to the patient. For example; a patient with PPHN needs to be provided with 100% O<sub>2</sub>, and an alkalotic state (pH 7.45 - 7.55 / pCO<sub>2</sub> 25-30), may require high frequency ventilation, nitric oxide, extracorporeal membrane oxygenation, and treatment by eliminating the cause if it can be found. A patient with hypoplastic left heart syndrome (HLHS) needs 21% O<sub>2</sub> with target saturations in the 70's, prostaglandin (PGE<sub>1</sub>) infusion to maintain ductal patency, ABG's (7.40 / CO<sub>2</sub> 40 / O<sub>2</sub> 40), and may require sedation for tachypnea. Withholding oxygen could cause the PPHN patient to spiral out of control and giving the HLHS patient 100% O<sub>2</sub> will cause decreased systemic blood flow and severe metabolic acidosis. This happens because the pulmonary vasodilation that occurs causes excessive blood flow to lungs decreasing systemic perfusion. Other problems arise because the ventilation goals are different and PGE<sub>1</sub> is contraindicated in the PPHN patient.

**Pearls:** You are probably thinking what could the pearls of this situation possibly be? Although an ECHO is ideal for diagnosis confirmation and helps make us feel confident in a chosen management plan, it is not necessary. Using the following stepped approach, usually can help to pinpoint a cardiac diagnosis and initiate appropriate treatment.

1. **Observation** – Take a minute and think about cyanosis. A severely anemic patient may not physically appear cyanotic. Remember that it takes a reduction of 3-5g of reduced hemoglobin per deciliter of arterial blood to be present before cyanosis can be visibly detectable. A patient with 2g of desaturated blood, 80% O<sub>2</sub> saturation and a hemoglobin of 10 will have no visual cyanosis. Other factors that effect hematocrit and the O<sub>2</sub> dissociation curve, such as polycythemia, also effect the appearance of cyanosis. After thinking about these concepts observe your patient. Is peripheral or central cyanosis present? Peripheral (acrocyanosis) is visible in the extremities and is related to the environment and or vasoreactive adjustments occurring in newborns. This type of cyanosis is common and differs from central. Central cyanosis is detectable in the mucous membranes and the patient often has a generalized pale gray or dusky appearance. Reverse differential cyanosis (blue upper extremities and pink lower extremities) is indicative of transposition of the great arteries with a possible arch obstruction. This type of differential cyanosis occurs because the right ventricle is pumping oxygenated blood into the pulmonary artery causing flow across the patent ductus arteriosus (PDA) into the descending aorta, which supplies the lower extremities.

2. **Auscultation** (see table 1) - Listening to your patients heart sounds can provide key information. Murmurs to a degree are present with most ductal dependant lesions, but remember they are also present in the PPHN patient. The presence of a gallop can be suggestive of aortic stenosis or Ebstein's anomaly and a systolic ejection murmur of pulmonary stenosis.

## 3. Respiration, Pulses, and Blood Pressures

- Normal newborns typically have a varied respiratory pattern and infants with cardiac lesions usually have a more regular pattern with tachypnea. Weak thready pulses equal low cardiac output. The absence of femoral pulses with an adequate BP indicates that you may have a left sided obstructive lesion. Equally poor pulses is suggestive of critical aortic stenosis, but also keep sepsis in mind. Differential upper extremity pulses (the right arm greater than the left) is indicative of coarctation of the aorta. Completion of four extremity blood pressures is a necessity. Upper extremity hypertension is also suggestive of an aortic coarctation. A narrow pulse pressure maybe noted in severe aortic stenosis.

4. **Ductal Saturations** – Neonates with pulse oximetry saturation less than 90% and no signs of respiratory distress are likely to have a cardiac defect rather than a pulmonary cause of their hypoxia. Compare your patient's pre (right radial) and post (lower extremity) ductal saturation's. A PaO<sub>2</sub> difference of 15 torr or a pulse ox difference of 10% between pre and post ductal oxygen saturations is suggestive of R>L shunting.

5. **Hyperoxia Test** – If the patient is able to tolerate, check their PaO<sub>2</sub> via ABG on 21% O<sub>2</sub> then increase the oxygen to 100% wait 5 – 10 minutes and draw another ABG. The results you obtain from these two gases can help to determine the cause of hypoxia. Most importantly for the purposes of this discussion, a PaO<sub>2</sub> < 100 at 100% FiO<sub>2</sub> with normal PaCO<sub>2</sub> levels indicates that congenital heart disease is likely to be present. The patient with a PaO<sub>2</sub> 100 – 200 on 100% FiO<sub>2</sub> suggests a complete mixing heart defect. A cardiac etiology is unlikely with a PaO<sub>2</sub> >250 on 100% FiO<sub>2</sub>.

6. **Chest Radiograph** (see table 2) - Venous congestion and increased or decreased pulmonary blood flow maybe evident (prominent or decreased vascular markings) in patients with cardiac defects. Decreased pulmonary vasculature is

*continued on page 6*

## Chairman's Corner

continued from page 1

I would like to take this opportunity to thank Tony Woodward for the excellent leadership he has given our section in the last five years. He has brought our section to the highest level of recognition within and outside the Academy. I hope you will join me in thanking Tony for providing us with his knowledge and guidance in the development of our section.

As you know, the success of the section depends on not just a few members on the executive committee, but on the entire membership as a collective leadership. I hope that you will continue your support for our section and encourage other colleagues of the various disciplines represented to join us in continuing the development of our section. I look forward to hearing from each and every one of you with recommendations, ideas, and suggestions in continuing the projects and work that lies ahead of us. I look forward to your participation in future section activities.

*David Jaimovich, MD*  
Chairman  
Section on Transport Medicine



Be Informed!!  
Get Involved!!

**Join the Section on  
Transport Medicine  
LISTSERV® Today!**

*The LISERV® allows SOTM members  
to communicate through periodic e-mail  
messages.*

If you would like to join the LISERV®  
simply: e-mail Stephanie Mucha at  
[smucha@aap.org](mailto:smucha@aap.org) with "SOTM  
LISTSERV" in the subject line.

**X Be sure to include your name and contact information. X**

## SOTM EXECUTIVE SUMMARY

continued from page 3

to the membership via the  
LISTSERV®.

- Dr. Hackel and Dr. Chung spoke to the Executive Committee about the concept of a national transport database and repository. The Committee was very interested in becoming involved in this initiative. The Committee thought this system would have many uses, including an ability to scientifically assess this new and vital specialty and service. Dr. Hackel asked the Committee to submit to him a few potential research questions that are applicable to the transport environment and would be facilitated by a national database.
- Dr. Jaimovich emphasized the importance of SOTM involvement in international activities in the future and mentioned his involvement in the 2003 World Congress. Dr. Jaimovich feels that it is important for the Section to determine a way to encompass a more global aspect of pediatric health care into its mission. It is very important to communicate basic fundamental guidelines for pediatric transport to countries that do not currently have access to or knowledge of such guidelines. It was suggested that an international subcommittee be established to look into ways the SOTM can better address international transport medicine issues.

The Executive Committee will meet during the 2001 AAP National Conference and Exhibition in San Francisco on October 22.

*Stephanie Mucha*  
Manager  
Section on Transport Medicine

## What is the CHILDisaster Network?

### Child Health International Large Scale Disaster Network

The Section on International Child Health is organizing a network of pediatric professionals who will be available to accompany organizations responding to disasters on a short-term notice. Child health professionals with education and experience in humanitarian emergencies will be available to volunteer their time and skills during a specific time period. Should an organization need child health experts on a project, the AAP will provide disaster relief organizations a list of practitioners who have completed a comprehensive application process. If you would like to be a part of this network, please visit the AAP Web site at [www.aap.org/disaster](http://www.aap.org/disaster) and submit an application. Should you have questions regarding the network, please contact Anne McGhiey at 800/433-9016, ext. 7658. The CHILDisaster Network is part of a global initiative developed in partnership with Johnson & Johnson Pediatric Institute, the International Pediatric Association, and the American Academy of Pediatrics to ensure the health and well-being of children in disaster situations. If you would like to make a donation to support the CHILDisaster Network please send your gift to the AAP Friends of Children Fund or call 888-700-5378.

*Johnson & Johnson* **pediatricinstitute**  
Division of Johnson & Johnson Consumer Companies, Inc.



The International  
Pediatric Association

American Academy of Pediatrics  
DEDICATED TO THE HEALTH OF ALL CHILDREN™



## Pearls and Pitfalls

continued from page 4

usually related to R>L shunting. Increased pulmonary vasculature is associated with L>R shunting, increased blood flow, or impaired pulmonary venous return. Tetralogy of Fallot presents as a boot shaped heart on x-ray. Transposition of the great arteries may be viewed as an egg on a string. A chest x-ray can also help to identify possible causes of PPHN such as a d-hernia or hypoplasia of the lungs.

7. **PGE1** - Remember if you start prostaglandins because you are suspecting a cardiac problem and your patient continues to decompensate the patient may have impaired egress of pulmonary venous return (mitral atresia with a restrictive patent foramen ovale, hypoplastic left heart syndrome with an intact atrial septum, or total anomalous venous return).

8. **EKG** (see table 3) - A 12 lead EKG can also provide some valuable information. Many times it is helpful to fax the 12 lead to the pediatric receiving cardiologist for a quick expert evaluation prior to transport.

Once you arrive at the referring hospital, establish the ABC's, gather a brief history, and complete your evaluation. If your evaluation leads you to suspect a ductal dependant lesion, and PGE1 has not already been started you should do so. Typically the infusion is started at 0.05 – 0.1 mcg/kg/min and once a therapeutic response is noted it is usually reduced to 0.025 mcg/kg/min. Apnea is a side effect of the drug. The need for intubation should be considered and initiated when required. After intubating, place an oral gastric or nasogastric tube and verify ease of placement. Midline abnormalities are frequently associated with cardiac defects. Assess ventilation (including prior ABG's and ventilator settings) and check an ABG before departing to see if adjustments are needed. Correct acidosis if indicated. When considering ventilator parameters keep in mind that positive end expiratory pressure

assists systemic circulation when ductal dependant lesions are present, but can be detrimental to flow in other cardiac anomalies. Sedate and paralyze your patient for intubation, and as needed to control ventilation and minimize the stress of the transport setting. Confirm intravenous (IV) access. Umbilical lines (arterial & venous) and an additional peripheral IV for the PGE1 infusion are ideal in these newborns. Having an arterial line allows for close observation of blood pressure changes and frequent ABG monitoring. Hypotension is a late finding of cardiovascular shock and a sign of impending decompensation. Conservative volume resuscitation and/or inotropes maybe needed in these patients. Vascular access and endotracheal tube placement should be verified by x-ray. Remember to keep your patient normothermic. In the mist of caring for these critical patients, this simple step is often forgotten. Hypo and hyperthermia both increase the patient's metabolic demands and O2 consumption. Many times these patients are so critically ill that air transport is indicated. Discuss the assessment findings and the mode of transport with the pediatric cardiology medical command physician. In some situations, until an ECHO can be completed the receiving operating room or cath lab may need to be placed on standby.

### Abbreviation Key:

**TGA w/IVS** = transposition of the great arteries with an intact ventricular septum  
**HLHS** = hypoplastic left heart syndrome  
**IAA** = interrupted aortic arch  
**CoARC** = coarctation of the aorta  
**AS** = aortic stenosis  
**TOF w/PA** = tetralogy of fallot with pulmonary atresia  
**PA w/IVS** = pulmonary atresia with an intact ventricular septum

### TABLE #1 Murmurs

**TGA w/IVS** Often no murmur present  
**HLHS** Usually absent / murmurs variable  
**IAA** Nonspecific ejection murmur  
**CoARC** Nonspecific ejection murmur  
**Critical AS** Systolic thrill / click / ejection murmur

**TOF w/PA** Usually absent / continuous murmur form collaterals

**PA w/IVS** Usually absent / tricuspid regurgitation or PDA murmur

**Ebstein's** Gallop / wide S2 split / tricuspid regurgitation murmur

\* A gallop is indicative of poor cardiac function.

### TABLE #2 X-rays

**TGA w/IVS** Cardiomegaly / egg on a string silhouette

**HLHS** Enlarged heart / increased PVM

**IAA** Cardiomegaly / increased PVM / pulmonary edema

**CoARC** Cardiomegaly / pulmonary edema / pulmonary venous congestion

**Critical AS** Normal or dilated ascending aorta with valvular AS / increased cardiac silhouette

**TOF** Normal or boot shaped heart / decreased PVM

**PA w/IVS** Normal to enlarged / RA enlargement / decreased PVM

**Ebstein's** Extreme cardiomegaly / decreased PVM

### TABLE #3 EKG

**TGA w/IVS** R axis deviation; RV hypertrophy

**HLHS** RV hypertrophy

**IAA** RV hypertrophy

**CoARC** RV hypertrophy (in neonates)

**Critical AS** RV or LV hypertrophy

**PA w/IVS** Normal QRS axis; RA hypertrophy; LV hypertrophy; Prominent LV forces; Decreased RV forces

**TOF w/PA** R axis deviation  
 Prominent R sided forces

**Ebstein's** RV conduction delay; RA hypertrophy; WPW syndrome; SVT; First degree AV block

\*EKG's are often non-specific: left axis deviation may indicate a complete atrio-ventricular canal defect or tricuspid atresia.

**SECTION ON CRITICAL CARE EXECUTIVE COMMITTEE**  
**EXECUTIVE SUMMARY**  
 October, 2000

The AAP Section on Critical Care (SOCC) Executive Committee met on October 28, 2000 during the AAP Annual Meeting in Chicago, IL. Michele Moss, MD will be the new SOCC chairperson, effective November 1, 2000 and Timothy Yeh, MD will be the ex-officio. Thomas Bojko, MD, was elected to serve as a new member of the executive committee. Current SOCC membership at large is 572, a 9% increase over the past 5 years.

The SOCC educational program for the 2000 AAP Annual Meeting included two half day sessions for abstract presentations, the Section business meeting, and awards. A joint session with the Sections on Cardiology, Emergency Medicine, and the Neonatal Resuscitation Program Steering Committee on new pediatric resuscitation guidelines was also conducted, along with sessions on acute lung injury, critical care procedures, sedation, and asthma. Topics for the 2001 AAP National Conference and Exhibition were discussed and the SOCC agreed to submit proposals for a joint program with the Sections on Neurology and Neurosurgery on treatment of acute head injuries. Other proposals will be submitted for plenary sessions on asthma and ethical issues in pediatric drug research, workshops on critical care procedures and sedation, and the Section's traditional abstract program. A call for nominations for the 2001 Distinguished Career Award and New Investigator Research Awards will be promoted via the next SOCC newsletter, the

PedsCCM Web site, and the SOCC page on the AAP Web site. The committee discussed a proposal that will be presented to the American Medical Association's CPT Editorial Board in February 2001 for establishment of new global pediatric critical care code for children 30 days - 24 months of age. Development of educational materials and training for critical care coding are also being explored. Major SOCC projects include development of a pediatric intensivist workload and compensation survey and revision of the 1993 policy statement on guidelines and levels of care for pediatric intensive care units. Other issues discussed related to current marketing of inhaled nitric oxide, opportunities for life long learning and self assessment in pediatric critical care as it relates to credentialing, exclusive physician contracts, intensive care for children in a comprehensive cancer center, legislation impacting the labeling and shortage of pediatric drugs no longer produced in the U.S., and critical care research.

Reports were provided on activities of the AAP Central Office, Council on Sections, Council on Sections Management, Committee on Coding and Reimbursement, Committee on Pediatric Emergency Medicine, Section on Anesthesiology, and Section on Transport Medicine.

The next SOCC executive committee meeting will be held during the Society of Critical Care Medicine Symposium, February 12, 2001 in San Francisco, CA from 8:00 am-3:00 pm.

*For a complete set of minutes or further information on specific items discussed at this meeting, please contact Sue Tellez, Division of Hospital & Surgical Services, at 800/433-9016 (x 7395).*

**SECTION ON CRITICAL CARE**  
**EXECUTIVE COMMITTEE**  
**2000-2001**

**Chairperson**

M. Michele Moss, MD  
 Little Rock, AR  
 EM: mossmichele@uams.edu

**Executive Committee Members**

Alice Ackerman, MD  
 Baltimore, MD  
 EM: aackerma@peds.umaryland.edu

Thomas Bojko, MD  
 Brooklyn, NY  
 EM: tbojko@maimonidesmed.org

Brahm Goldstein, MD  
 Portland, OR  
 EM: goldsteb@ohsu.edu

Stephanie A. Storgion, MD  
 Memphis, TN  
 EM: sstorgion@utmemo.edu

Otwell Timmons, MD  
 Charlotte, NC  
 EM: otimmons@carolinas.org

**Past Chairperson:**

Timothy S. Yeh, MD  
 Oakland, CA  
 EM: timbobyeh@aol.com

**AAP Staff:**

Sue Tellez  
 Elk Grove Village, IL  
 EM: stellez@aap.org

**SECTION ON EMERGENCY MEDICINE EXECUTIVE COMMITTEE  
EXECUTIVE SUMMARY  
October, 2000**

The AAP Section on Emergency Medicine (SOEM) Executive Committee met on October 27, 2000 in conjunction with the AAP Annual Meeting in Chicago. Richard Ruddy, MD will be the new SOEM chairperson effective November 1, 2000 and Douglas Baker, MD will be the ex-officio. Drs Mark Joffe and Nathan Kuppermann were elected to serve as new members of the executive committee. Current SOEM membership is 835 and has grown by approximately 30% over the past five years.

The SOEM educational program for the 2000 AAP Annual Meeting will include abstract and poster presentations, EmergiQuiz, a joint session with the Sections on Cardiology and Critical Care on new pediatric resuscitation guidelines, a session on sedation and pain management in the emergency department, and a session on administrative issues in handling children with high-risk diagnoses in the emergency department. The 2<sup>nd</sup> Ken Graff Young Investigator Research Award winner will also be announced. Topics for the 2001 AAP National Conference and Exhibition were discussed and the SOEM agreed to submit proposals for a workshop on troubleshooting indwelling medical devices in the emergency department, a workshop on managing children's wounds, a selected short subject on equipping the office for pediatric emergencies, a selected short subject on unusual presentations, and a seminar on management of fever in the emergency department. Three topics will be addressed during the Section program including psychiatric

emergencies, administrative issues, and bioterrorism. It was noted that the next Fellows Conference will be held on March 24-26, 2001 and that the Ambulatory Pediatric Association will hold a conference on pediatric emergency medicine research on March 30-April 1, 2001 in Reston, VA. The next PREP-EM course is slated for summer 2002. Options for a future Leadership Retreat are being explored.

Reports were provided on activities of the AAP Central Office, Council on Sections, Council on Sections Management, Committee on Coding and Reimbursement, Section on Residents, and the Section on Pediatric Emergency Medicine of the American College of Emergency Physicians. Section subcommittee reports were provided on Pediatric Emergency Medicine in Non-Children's Hospitals, Administrative/Practice Guidelines, Emergency Medical Services, Fellowship, and Research. *Emergency Medicine News* continues to be published biannually. The SOEM strategic plan was distributed to the membership-at-large via the fall newsletter and posted to the Section's page on the AAP Members Only Channel. Comments provided at the Section business meeting will be incorporated into the final document.

The next SOEM executive committee meeting will be held the first or second weekend of March 2001. The location is to be determined.

*For a complete set of minutes or further information on specific items discussed at this meeting please contact Sue Tellez, Division of Hospital & Surgical Services, at 800/433-9016 (x 7395).*

**SECTION ON EMERGENCY  
MEDICINE  
EXECUTIVE COMMITTEE  
2000-2001**

**Chairperson**

Richard Ruddy, MD  
Cincinnati, OH  
EM: richard.ruddy@chmcc.org

**Chairperson-elect**

Daniel J. Isaacman, MD  
Norfolk, VA  
EM: disaacma@chkd.com

**Executive Committee Members**

Laura Fitzmaurice, MD  
Kansas City, MO  
EM: lfitzmaurice@cmh.edu

Mary A. Hegenbarth, MD  
Kansas City, MO  
EM: mhegenbart@cmh.edu

Mark D. Joffe, MD  
Wynnewood, PA  
EM: joffe@email.chop.edu

Nathan Kuppermann, MD, MPH  
Sacramento, CA  
EM: nkuppermann@ucdavis.edu

Joan E. Shook, MD  
Houston, TX  
EM: jeshook@texaschildrenshospital.org

**Past Chairperson:**

M. Douglas Baker, MD  
New Haven, CT  
EM: douglas.baker@yale.edu

**AAP Staff**

Sue Tellez  
Elk Grove Village, IL  
EM: stelvez@aap.org

2001 AAP National Conference  
& Exhibition  
San Francisco, CA  
October 20-24, 2001



**A Note from the  
Program Chair**

Conference and Exhibition (NCE) this Fall in San Francisco, we are looking forward to having an exciting interactive Section session. One of the topics will be an update on the status of clinical research in transport medicine. In preparation, if you are involved in a transport clinical research project or have an idea for one and would like your project or idea mentioned/discussed, please let me know.

I can be reached via e-mail at [Rinsoft@partners.org](mailto:Rinsoft@partners.org) by telephone at 617/724-9016 or by fax at 617/724-9346.

SCIM Executive  
Committee Member  
Program Chair  
AAP 2001 NCE

**Section on Transport  
Medicine Section Program  
Monday, October 22, 2001  
12:00pm-6:00pm**

**12:30 pm – 2:00 pm**  
**Section Business Meeting and Lunch\***  
(All SOTM members are invited to the business meeting-Please Join Us!)  
\*Advance purchase of lunch ticket required

**2:00 pm – 2:15 pm**  
**International Transport  
Committee Initiative**

**2:15 pm – 2:30 pm**  
**SOTM Research Committee  
Update: National Research  
Database Project**  
*Robert Insoft, MD*

**2:30 pm – 3:30 pm**  
**Should Residents Participate on  
Transport?  
Panel Discussion and Debate**  
*Tony Pearson-Shaver, MD, Moderator*  
*C. Robert Chambliss, MD, Faculty*  
*Robert Insoft, MD, Faculty*  
*Monica Kleinman, MD, Faculty*

**3:30 pm – 3:45 pm**  
Break

**3:45 pm – 4:30 pm**  
**Fascinating Transport Cases: Not  
Always as First Described**  
*Tony Woodward, MD*

**4:30 pm – 5:30 pm**  
**Scientific Abstract Presentations**

**5:30 pm**  
**Scientific Awards Presentations**



The American Academy of Pediatrics (AAP) is a partner in National Emergency Medical Services (EMS) Week, May 20-26, 2001, coordinated by the American College of Emergency Physicians (ACEP). **Wednesday, May 23** has been designated as National Emergency Medical Services for Children (EMSC) Day, with a focus on child safety and injury prevention. For press releases and fact sheets on National EMS Week, go to [www.acep.org/emsweek](http://www.acep.org/emsweek).

**STEER CLEAR OF  
UN-SECURE E-MAIL**

The AAP and other leading medical societies, top malpractice carriers, and Medem, are recommending that physicians avoid standard un-secure e-mail for online communications with patients, in order to protect patient confidentiality as well as reduce their own liability. Instead, physicians should select a secure messaging solution, and refer to eRisk for Providers, a set of guidelines that addresses all aspects of the online physician-patient relationship. Read more at

[www.medem.com/Corporate/press/corporate\\_medeminthepress042.cfm](http://www.medem.com/Corporate/press/corporate_medeminthepress042.cfm)

**SECTION ON TRANSPORT MEDICINE (SOTM)  
EXECUTIVE COMMITTEE & ADDITIONAL SUBCOMMITTEES/LIAISONS  
2000-2001**

David G. Jaimovich, MD, Chairperson  
Chief, Div of Ped Critical Care  
Medical Director, Pediatric Transport  
Program  
Hope Children's Hospital  
4440 W 95th St, Rm 3192H  
Oak Lawn, IL 60453  
708/346-5685; FAX: 708/346-4712  
david.jaimovich@advocatehealth.com  
(1<sup>st</sup> Term Expires 10-2002)

Thomas J. Abramo, MD  
Dept of Pediatrics  
Southwestern Medical Cntr  
1935 Motor St  
Dallas, TX 75235-7701  
214/456-8314; FAX: 214/456-6014  
tabram@mednet.swmed.edu  
(2<sup>nd</sup> Term Expires 10-02)

C. Robert Chambliss, MD  
Children's Healthcare of Atlanta at  
Egleston  
Div of Critical Care  
1405 Clifton Rd, NE  
Atlanta, GA 30322-4510  
404/325-6397; FAX: 404/325-6233  
robert.chambliss@choa.org  
(1<sup>st</sup> Term Expires 10-2003)

Robert Insoft, MD  
Director, Pediatric Transport Services  
Massachusetts General Hospital  
Partners HealthCare Systems, Founders  
House 442  
Boston, MA 02114  
617/724-9040; FAX: 617/724-9346  
rinsoft@partners.org  
(1<sup>st</sup> Term Expires 10-02)

Brent R. King, MD  
Dept of Emergency Medicine  
6431 Fannin St, Suite 6.234  
Houston, TX 77030  
713/500-7863; FAX: 713/500-0503  
brent.king@uth.tmc.edu  
(1<sup>st</sup> Term Expires 10-03)

Monica Kleinman, MD  
Medical Director, Transport Program  
Children's Hospital  
MICU Office – Farley 517  
300 Longwood Avenue  
Boston, MA 02115  
617/355-7327; FAX: 617/734-3863  
monica.kleinman@tch.harvard.edu  
(1<sup>st</sup> Term Expires 10-03)

Anthony L. Pearson-Shaver, MD  
Dept of Pediatrics  
Children's Medical Center  
1446 Harper St, BT 2641  
Augusta, GA 30912-3758  
706/721-4402; FAX: 706/721-7872  
tpearson@mail.mcg.edu  
(1<sup>st</sup> Term Expires 10-02)

**IMMEDIATE PAST CHAIRPERSON:**

George A. Woodward, MD, MBA  
Director, Transport Services  
Children's Hospital Philadelphia  
3400 Civic Center Blvd  
Philadelphia, PA 19104  
215/590-4988; FAX: 215/590-1394  
woodwardg@email.chop.edu

**SUBCOMMITTEES**

**2001 National Conference  
and Exhibition Program  
Co-Chairpersons:**

C. Robert Chambliss, MD  
Robert Insoft, MD

**2002 National Conference  
and Exhibition Program  
Co-Chairpersons:**

C. Robert Chambliss, MD  
Brent King, MD

**CME Course Planning Committee:**

Robert Insoft, MD  
Monica Kleinman, MD

**Nominating Committee:**

Anthony Pearson-Shaver, MD  
OPEN

**Membership Chairperson:**

Thomas Abramo, MD

**ICD Representative:**

David Jaimovich, MD

**Research:**

Robert Insoft, MD  
Monica Kleinman, MD

**Newsletter Co-Editors:**

Kirsten Johnson Moore, RN, MSN  
Director, Emergency Nursing Services  
Children's Hospital of Philadelphia  
34th St and Civic Center Blvd  
Philadelphia, PA 19104  
215/590-2268; FAX: 215/590-1394  
[moore@email.chop.edu](mailto:moore@email.chop.edu)

Phillip V. Gordon, MD, PhD  
Pager: 919/966-7243, #123-6812  
EM: [pgordon@med.unc.edu](mailto:pgordon@med.unc.edu)

**LIAISONS:**

**National Conference and Exhibition  
Planning Group Representative:**

Loren Yamamoto, MD  
Dept of Pediatrics  
1319 Punahou St, #718  
Honolulu, HI 96826-1032  
Office: 808/973-8387  
FAX: 808/949-4232  
EM: [loreny@hawaii.edu](mailto:loreny@hawaii.edu)

**Section on Critical Care:**

M. Michele Moss, MD  
Arkansas Children's Hospital  
800 Marshall Street  
Little Rock, AR 72202-3591  
501/320-1479; FAX: 501/320-3667  
[mossmichele@exchange.uams.edu](mailto:mossmichele@exchange.uams.edu)

**Section on Perinatal Pediatrics:**

Philip Gary Pettett, MD  
Dept of Peds, Section of Neonatology  
Children's Mercy Hosp  
2401 Gillham Rd  
Kansas City, MO 64108  
816/234-3594; FAX: 816/234-3590

**Liaison to Section on Critical Care**

Anthony L. Pearson-Shaver, MD

**Liaison to Section on Perinatal  
Pediatrics**

TBD

**Commission on Accreditation of  
Medical Transport System (CAMTS)**

Richard Orr, MD

**Steering Committee Member  
of AAP Pediatric Education for  
Pre-Hospital Professionals (PEPP)  
Program**

George Anthony Woodward, MD

**AAP STAFF:**

Stephanie Mucha, Manager  
Div of Hospital & Surgical Services  
Dept of Committees/Sections  
141 Northwest Point Blvd  
PO Box 927  
Elk Grove Village, IL 60007  
800/433-9016, ext 4799  
FAX: 847/434-8000  
EM: [smucha@aap.org](mailto:smucha@aap.org)



***Are you currently involved in international transport medicine activities?***

***Have you done overseas relief work in the past?***

Dr. Jaimovich, Chairperson, Section on Transport Medicine (SOTM) feels that it is important for the Section to determine a way to encompass a more global aspect of pediatric health care into its mission.

Dr. Jaimovich is currently making efforts to create an international subcommittee within the AAP to look into ways the SOTM can better address international transport medicine issues.

We would like some input and information from you, the SOTM membership.

Name: \_\_\_\_\_ Degree: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

\_\_\_ Yes, I have been involved in overseas activities

Countries I have worked in: \_\_\_\_\_

\_\_\_\_\_

Languages I speak: \_\_\_\_\_

Please describe your activities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you been in involved in any AAP-related international activities? Please describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please fax back to Stephanie Mucha at 847/434-8000 by July 2, 2001**

**If you would rather e-mail your response, please send an e-mail to David Jaimovich at [david.jaimovich@advocatehealth.com](mailto:david.jaimovich@advocatehealth.com)**