Chairperson’s Report
Raeford Brown, MD, FAAP

As I mentioned in my last message from the fall newsletter, following Rita Agarwal and Joe Tobias in this role of AAP Section on Anesthesiology and Pain Medicine Chairperson will be a daunting task. They have both added immeasurably to the stature and progress of the Section and we should all be thankful to them. But, alas, it’s time to move ahead.

The AAP is an advocacy organization dedicated to improving the health and well-being of all infants, children, and adolescents. The focus of the larger organization and our Section is quite different from that of the ASA and the SPA, which have evolved more as educational and research venues. My experience while working with the Food and Drug Administration is that there is great respect by the Agency for the AAP. Principals from the FDA sit on the AAP Committee on Drugs, the AAP Federal Office is a first stop for concerns relating to the care of children, and there is an uncharacteristic reverence, unspoken, but sensed in the relationship. Much of the work of the AAP and our section is done behind the scenes. Advocacy involves understanding children’s needs and communicating with individuals in other professional organizations, with governments, both state and local, and with the general public. The work is demanding, but the opportunities to provide a better life for infants, children, and adolescents are significant. The AAP and the SOA serve as the home base for those that have a commitment to improving the lot of the less powerful. All are welcome.

Our Section Executive Committee met last in October and will meet again in late March, in part to discuss the membership of the Section. We would certainly like to maintain or grow the membership, but more important is the need to communicate the extent to which the section can provide an opportunity for career development through availability of leadership roles. Currently, nearly all the work of the section is divided among the seven members of the executive committee. Going forward, we would like to divide the work and provide leadership roles to those within the section who are interested.

Our Section is a member of a larger group within the AAP known as the Surgical Advisory Panel (SAP), which is composed of the SOA, all of the pediatric surgical subspecialties, and the Section on Pediatric Radiology. Connie Houck, a former Chair of the SOA, currently leads the SAP. Our involvement at a high level as part of the SAP is important, as advocacy for critical issues of interest to all groups involved in perioperative pediatrics is best served by combined efforts. As this group advocates for our interests, I will report on successes and any actions that we might take to support the good work that Connie is doing.

The Section on Anesthesiology and Pain Medicine, under the leadership of Rita Agarwal, extended a hand to all organizations involved in the perioperative anesthetic care of children including the Committee on Pediatric Anesthesia of the ASA, the SPA, and the Society for Pediatric Pain Medicine. It has been our goal to speak with one voice for our profession and our patients, to provide the best and broadest educational experience for all of the groups, and to engage the leadership of each group in the consideration of some very significant issues facing Pediatric Anesthesiology in the next decade. To that

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end the Chairs of each of these groups is invited to each of our Section Executive Committee meetings, I will sit on the Executive Committee of each of the other organizations, and the membership of each of the groups will receive in their newsletters a report on the activities of our Section.

Elsewhere in this newsletter you will find reports of our involvement within and outside of the American Academy of Pediatrics. Currently, the section is finalizing the revision of the Academy's Acute Pain policy statement and will soon pass a new policy statement on Pediatric Chronic Pain Management to the Board of Directors of the AAP for review and approval. A clinical report on the use of Oxymetazoline in children is also in the works along with a new report on Perioperative Management of Children with Sleep Disordered Breathing/Obstructive Sleep Apnea; several members of the Section are also involved in an AAP Task Force concerning the safety hazard posed by button batteries. In addition, with Charlie Côté and Rita Agarwal in the lead, our involvement in the current national discussion on deaths from sedation of children in dental offices continues apace.

Another item of note is that the American Society of Anesthesiologists, through its Committee on Pediatric Anesthesiology, has asked Drs. Randall Flick, Lena Sun, Mary Ellen McCann and myself to develop a consensus statement on neurotoxicity of general anesthetic agents in the developing brain. We will begin to work on this at the spring meeting with the hopes that it can be presented to the ASA Board of Directors during the meeting in San Francisco. A featured panel at the ASA meeting will bring together the group to expand on the statement and to answer questions concerning the perceived need for changes in current practice. In addition, Lisa Wise-Faberowski and I have been asked to give a presentation during the Spring Meeting of the Society for Pediatric Otolaryngology and the Section on Otolaryngology of the AAP in Washington, DC, in April.

This is an active time in the life of the Section, and there are many opportunities for involvement and leadership that we hope you will consider. With our very busy Executive Committee at the helm, we are indeed moving to the future.

AAP –Sponsored Events and Awards at the 2018 Winter Meeting
March 23-25, 2018 – Phoenix, Arizona

The AAP Section on Anesthesiology and Pain Medicine takes great pleasure in having the opportunity to partner with the Society for Pediatric Anesthesia (SPA) each year in offering the SPA/AAP Winter Meeting. This year’s joint meeting will take place March 23-25 in Phoenix. The mobile meeting guide can be viewed at: http://www2.pedsanesthesia.org/meetings/2018winter/guide/

The AAP proudly sponsors a number of events and awards at the annual Winter Meeting. Please read on for information about the 2018 AAP Ask the Experts Panel, AAP Advocacy Lecture, John J. Downes Resident Research Award winners, and the esteemed 2018 Robert M. Smith Award winner.

AAP Ask the Experts Panel
Saturday, March 24, 2018
1:45 – 2:45 pm

Moderator:
Lisa Wise-Faberowski, MD, FAAP
Stanford University
Stanford, CA

Topics and Panelists:
Toddlers & Button Batteries: A Deadly Combination
Debnath Chatterjee, MD
Children’s Hospital Colorado/University of Colorado
Aurora, CO

Upon completion of this session, the participant will be able to:
• Describe the mechanism of injury following button battery (BB) ingestion
• Formulate an algorithm for the management of a toddler with suspected BB ingestion
• Recognize the clinical presentation of an aorto-enteric fistula following BB ingestion
• Discuss recent legislation and technological advances aimed at improving the safety profile of lithium batteries

How to Intubate the Difficult Airway on your First Attempt
John Fiadjoe, MD
Children’s Hospital of Philadelphia
Philadelphia, PA

Upon completion of this session, the participant will be able to:
• Identify the three essential techniques for securing the difficult pediatric airway
• Describe techniques to oxygenate during intubation
• Understand the impact of a QI process in airway management

AAP Advocacy Lecture
Unique Healthcare Challenges in Immigrant and Refugee Children
Friday, March 23, 2018
1:30 – 2:30 pm

Marsha R. Griffin, MD, FAAP
Director, Division of Child and Family Health
University of Texas Rio Grande School of Medicine
Brownsville, Texas

Marsha Griffin, MD, is Director, Division of Child and Family Health, at the University of Texas Rio Grande Valley School of Medicine, and co-founder of Community for Children, an organization committed to preparing future physicians to provide compassionate, effective leadership within community collaborations. In addition, Dr. Griffin
Amanda Foley is clinical adjunct faculty for the UTHSCSA Regional Academic Health Center. Dr. Griffin received her medical degree from the UTHSCSA in 2003 and completed her residency in general pediatrics at Baylor College of Medicine in Houston, Texas, and the University of Texas Health Science Center at San Antonio in June 2006. Prior to her medical career, Dr. Griffin completed graduate studies in the theology of social justice at United Theological Seminary in New Brighton, Minnesota. She was founder and, from 1988 to 1999, executive director of the FOCUS Foundation, a nonprofit organization that produced documentary films concerning adolescents and their struggle for success. As director of housing services for the Central Community Housing Trust in Minneapolis, Minnesota, from 1996 to 1999, she was instrumental in developing housing and services in the inner-city for homeless, former addicts, Somali refugees, and street children. A lifelong advocate for the underserved, Dr. Griffin has served as a board member for numerous community-based organizations both nationally and internationally and provided care in countries such as Haiti, Ecuador and Nicaragua.

Upon completion of this session, the participant will be able to:
- Understand the growing magnitude of global migration
- Distinguish between migration-related trauma: pre-migration, migration, border crossing and detention trauma
- Discuss the effects of flight, trauma, and stress on mental health
- Identify next steps in advocacy in your own healthcare facility

2018 AAP John J. Downes Resident Research Award Winners

Each year, the AAP Section on Anesthesiology and Pain Medicine selects abstracts to receive the American Academy of Pediatrics John J. Downes Resident Research Award. This year’s winners are:

1st Place
Amanda Foley, MD, University of Michigan
Race and Perioperative Critical Airway Complications in Children Undergoing Ear, Nose and Throat Procedures

2nd Place
Priya Brian Joseph, MD, Driscoll Children's Hospital
Adequacy of a Single Dose of Vancomycin for Antimicrobial Prophylaxis for Posterior Spinal Fusion Surgery for Adolescent Idiopathic Scoliosis

3rd Place (Tie)
Hina Walia, MD, Nationwide Children's Hospital
Readmission Rates Following Adenotonsillectomy in Pediatric Patients: Trends at Major Pediatric Hospitals

3rd Place (Tie)
Miguel Yaport, MD, Children's Hospital of Philadelphia
STBUR: Sleep Trouble Breathing and Unrefreshed Questionnaire: Evaluation of Screening Tool for Post-anesthesia Care and Disposition

The presentation of the 2018 AAP Robert M. Smith Award will take place on Friday, March 23, from 1:15 to 1:30pm, preceding the AAP Advocacy Lecture.

A Tribute to Dr. Robert H. Friesen for the Dr. Robert M. Smith Award

By Mark D. Twite, MB BChir FRCP
Department of Anesthesiology, University of Colorado Anschutz Medical Campus and Children’s Hospital Colorado

Dr. Robert Moors Smith (1912-2009) was a pioneer of modern anesthesia practice and was considered by many to be the ‘father of pediatric anesthesiology’ in the United States. Dr. Smith trained as a surgeon and enlisted in the Army when the United States entered World War II (WW II). However, because of the great need for anesthesiologists in the military, he was given a three-month training course in anesthesia and for the next four years he served as the Chief of Anesthesia with the 100th General Hospital in France and Germany including at the Battle of the Bulge rising to the rank of Major. Like many servicemen who became anesthesiologists during WW II, Dr. Smith pursued a post-war career in anesthesia. In 1946 after he was released from the Army, he was appointed the first physician Chief of Anesthesia at Children's Hospital Boston. Though he initially had little experience caring for children, he supervised several nurses at Children’s Hospital Boston who until then provided the majority of anesthesia at the institution. The chief nurse anesthetist, Betty Lank, showed him the small blood pressure cuffs and masks an engineer at the hospital had fashioned for pediatric patients at her direction before any of these were commercially available. She used these items when providing anesthesia for the surgeon, Dr. Robert Gross, when he initiated the field of congenital cardiac surgery in 1938 by ligating the first patent ductus arteriosus. Dr. Gross went on to become Chairman of the Department of Surgery at Children's Hospital Boston, and he and Dr. Smith worked together to help establish the modern era of pediatric surgery and anesthesia. In the 1950s when the monitoring of infants and children consisted primarily of visual observation of the patient and intermittent palpation of the patient's pulse, Dr. Smith pioneered a new approach of continuous physiological monitoring by using a (precordial) stethoscope, taped on the chest wall over the
The careers of Dr. Robert Smith and Dr. Robert Friesen have many similarities. Both of them started out as surgeons but ended up as anesthesiologists, with an interest in developing safe, clinical anesthesia care for children. They both pursued similar clinical interests in pediatric cardiac anesthesia and research in monitoring modalities. Like Dr. Smith was, Dr. Friesen is a well-mannered, soft spoken gentleman whose presence in the operating room always has a calming influence even in the most trying circumstances. These two gentlemen with their quiet demeanor and great clinical competence inspired those around them to do their best.

Dr. Robert Friesen retired from clinical practice in 2017 with a long, distinguished career as an academic pediatric anesthesiologist at the University of Colorado and Children’s Hospital of Colorado, which is documented in a recent issue of the journal, Pediatric Anesthesia (1). Dr. Friesen earned his undergraduate degree at Duke University and attended medical school at the University of Kansas. After graduating from medical school, Dr. Friesen started his surgical internship at the University of Colorado. Fortunately, one of his early rotations was in anesthesiology, as he quickly realized he was much more interested in the practice of anesthesia rather than surgery. After meeting with the Chairman of the Department of Anesthesiology, Dr. Peter Cohen, he was able to change tracks and start an anesthesia residency. During his pediatric anesthesia rotation, Dr. Friesen worked with Dr. Charlie Lockhart, who fostered his interest in academic pediatric anesthesiology with an interest in cardiac anesthesia. Dr. Lockhart was the recipient of the Robert M. Smith Award in 2015. To gain further experience in the field of pediatric cardiac anesthesia, Dr. Friesen organized a year of training abroad, in the United Kingdom at St. Thomas’ Hospital and Great Ormond Street Hospital. This resulted in his first peer reviewed publication with Dr. A. Clements on measuring individual responses to heparinization for cardiopulmonary bypass with the early use of activated clotting time (2). This year was also the start of a lifelong friendship with Dr. Ted Sumner, who later became the Editor-in-Chief of the journal Pediatric Anesthesia, and who would then invite Dr. Friesen to join the editorial board. After his year of training in London, Dr. Friesen returned to Colorado in 1976 to begin his career at the Children’s Hospital of Colorado. He was the fifth pediatric anesthesiologist in the department. These were the formative years of the specialty of pediatric anesthesia, and Dr. Friesen’s research interests reflect the important clinical issues of the time.

In the 1970s and early 1980s, Halothane was the only choice for the inhaled induction of anesthesia in infants and children. Animal research demonstrated that the cardiovascular depression associated with halothane was more severe in newborn animals than older ones, presumably because the immature myocardium was more sensitive to depression (3-5). Rackow and Salanitre showed the increased incidence of cardiac arrest in infants undergoing general anesthesia, contributing to the mounting evidence that the cardiovascular depression by halothane was more severe in human infants (6). In a prospective study, Dr. Friesen demonstrated for the first time that at equipotent doses of halothane, blood pressure depression was greater in neonates and infants less than 6 months of age than in older children (7).

Additional prospective studies of halothane induction of anesthesia in infants documented a mean decrease in blood pressure of 50% that could be attenuated by pretreatment with atropine to maintain heart rate (8). A similar study of isoflurane followed, in which similar hemodynamic changes were observed, and a high incidence of airway irritability and laryngospasm that precluded isoflurane from being a suitable inhalation induction agent (9). In further studies, Dr. Friesen demonstrated that the hypotension associated with halothane use in infants could be attenuated with pretreatment using oral atropine and was exacerbated by prolonged preoperative fasting (10, 11).

Much of this early research work was made possible with the introduction of improved monitoring. When Dr. Friesen started out, the only vital signs commonly monitored by pediatric anesthesiologists were temperature, ECG and heart tones using the precordial stethoscope, all of which had been introduced into clinical practice by Dr. Robert Smith. Experienced practitioners could listen to changes in heart tones during the induction of anesthesia with halothane, and titrate the amount of halothane to avoid cardiac arrest. Measuring blood pressure at that time was done manually, with a blood pressure cuff and stethoscope, listening for the changes in Korotkoff sounds. While this worked in older children it was very difficult to do in infants. Instead a Doppler probe was used, typically over the brachial or radial arteries, to listen for blood pressure changes during cuff inflation. In the late 1970s, Dr. Maynard Ramsey, introduced the ‘Dinamap’, an acronym for ‘Device for Indirect Non-invasive Mean Arterial Pressure’, the first automated system to non-invasively measure blood pressure using an oscillometric method (12). Quick to realize the importance of this monitor in pediatric anesthesia, Dr. Friesen, working with one of his trainees, Lance Lichotar, conducted perhaps the first non-industry sponsored study of the Dinamap, demonstrating that its measurements were accurate in neonates and infants (13).

As with the Dinamap, another new monitor came along and captured Dr. Friesen’s attention. This was the Ladd Steritek Intracranial Pressure Monitor, a non-invasive monitor of intracranial pressure for neonates with open fontanelle. The halothane anesthetic techniques at the time often resulted in large changes in blood pressure and intraventricular hemorrhage. Working with Rita Thieme, a neonatal nurse practitioner, Dr. Friesen conducted a series of studies on the changes in anterior fontanelle pressure with different anesthetic agents, during cardiopulmonary bypass and hypothermic circulatory arrest, but perhaps the most important of these studies demonstrated a 200% increase in intracranial pressure during awake tracheal intubation of preterm neonates (14-17). This latter finding has changed the way neonates are intubated in the operating room, with them under anesthesia, but has been slower to catch on in many neonatal intensive care units.

Many of these research studies on halothane and ‘new’ monitoring technologies in neonates took place in the cardiac operating room. Dr. Friesen continued to research pertinent clinical questions in the field of congenital cardiac anesthesia. Due to the problems associated with halothane anesthesia, synthetic opioids were widely used as they had minimal hemodynamic effects, even at high doses (18). Dr. Friesen worked with his anesthesia colleague, Desmond Henry, to confirm the lack of significant cardiovascular side effects in studies using fentanyl as the sole anesthetic agent in neonates (19). Further work with an anesthesia trainee, Jim Glenski, demonstrated the safety of high doses of fentanyl and sufentanil as anesthetics for pediatric cardiac...
anesthesia, and work with another trainee, Raphael Campanini, studied the use of remifentanil for fast track cardiac anesthesia (20, 21). One of problems faced in the cardiac operating room is the coagulopathy associated with cardiopulmonary bypass. Before the advent of ‘miniaturized’ heparin coated bypass circuits, neonates were placed on cardiopulmonary bypass using large volume cardiopulmonary bypass circuits resulting in a dilutional coagulopathy. Dr. Friesen studied techniques to reduce this and demonstrated that both modified ultrafiltration and the infusion of fresh autologous whole blood led to significantly improved coagulation status following cardiopulmonary bypass (22, 23). A monitor which entered clinical practice much later in Dr. Friesen’s career was Near Infrared Spectroscopy (NIRS). While it was initially employed to monitor cerebral saturations in patients undergoing cardiopulmonary bypass surgery, Dr. Friesen recognized its use to monitor the gut in neonates with complex congenital heart disease who have an increased morbidity from gut ischemia. Working with a critical care trainee, Jon Kaufman, they determined that monitoring splanchnic regional oxygen saturation with a NIRS sensor placed over the anterior abdomen was an accurate monitor of gut perfusion and oxygenation and was superior to a sensor placed in the dorsolateral position for that purpose (24).

Dr. Friesen has always focused on the delivery of excellent clinical care to pediatric patients as a central theme to his research. When new monitoring technologies were introduced, usually for the adult population, he wanted to see how the new technologies could be applied to children and what new things pediatric anesthesiologists could learn. When the bispectral index monitor of hypnotic depth was introduced (BISTM Medtronic, Minneapolis, MN), he validated its use as a sedation monitor by finding good correlation with validated sedation scores and then demonstrated that procedural sedation by non-anesthesiologists often attained the depth of general anesthesia (25-27).

The University of Colorado, located in the mile-high city of Denver, is well known for its pulmonary hypertension research and patient population with the disease. During his career, Dr. Friesen has worked with cardiology colleagues to care for numerous pediatric patients with pulmonary hypertension. Many studies have demonstrated the increased risk of perioperative mortality in patients with pulmonary hypertension (28). Dr. Friesen conducted one of the first studies which documented the high risk of cardiac arrest in children with pulmonary hypertension undergoing non-cardiac procedures (29). He also studied the potential for respiratory depression during both preoperative and procedural sedation in cardiac patients and raised the concern that this could cause an increase in pulmonary vascular resistance in patients with pulmonary hypertension (30, 31). In addition, Dr. Friesen studied the pulmonary hemodynamic effects of a newer anesthetic drug, dexmedetomidine, and a controversial older anesthetic drug, ketamine, in children with and without pulmonary hypertension, and concluded that both drugs could be safely used (32, 33).

One of the keys to success in Dr. Friesen’s research career, has been asking the right questions. He identifies an important clinical problem and then formulates a study to help answer it. Along his career path, Dr. Friesen has shared his passion for the anesthesia care of patients and his wisdom in conducting research. Many of his research projects have been conducted with trainees and students, who have co-authored more than half of his peer reviewed papers. In addition, he has mentored many fellows who have earned trainee research awards for studies conducted under his guidance.

Pediatric anesthesia began to emerge as a subspecialty in the 1960s. Herbert Rackow and Ernest Salanitre, both academic anesthesiologists at Columbia University, made significant contributions to developing the specialty. They were charter members of the Section on Anesthesiology and Pain Medicine of the American Academy of Pediatrics (AAP), founded in 1965, with Rackow being the section’s first chair. At the annual meeting of the Section in April 1990, Dr. Friesen, as the program chair, having earlier nominated these two pioneers in pediatric anesthesia for the Robert M. Smith award, had the honor of presenting it to both (34). In 2015, in Aberdeen, Scotland at the Annual Meeting of the Association of Paediatric Anaesthetists of Great Britain and Ireland (APA), Dr. Friesen was recognized for his outstanding contributions to the field of pediatric anesthesia with Honorary Membership of the APA.

As Dr. Robert H. Friesen retires from clinical practice, but continues his academic interests as Professor Emeritus, he achieves the highest recognition that can be given to a pediatric anesthesiologist in the United States, the Robert M. Smith award. The Section of Anesthesiology and Pain Medicine of the AAP represents a community of pediatric anesthesiologists who all feel this award is well deserved. Congratulations!

**References**


(Continued from page 5)


Medicine Safety for Children: We All Play a Role

All physicians can take part in educating families about the importance of safe storage and disposal of medications! Leaders from our AAP Section on Anesthesiology and Pain Medicine recently helped the AAP develop a poster on Medicine Safety for Children and Teens. The poster can be downloaded at: https://www.aap.org/en-us/Documents/cosup_poster.pdf. It is designed specifically so that local resources can be added to it. We ask physicians using this resource in their offices or as a handout to patients to consider using the available space at bottom for adding phone numbers or websites of local take back programs and resources in the area. Here are some websites that may help with looking for local resources:

- https://apps.deadiversion.usdoj.gov/pubdispsearch
- www.deadiversion.usdoj.gov/drug_disposal/overdose
- www.deadiversion.usdoj.gov/drug_disposal/takeback
- www.deadiversion.usdoj.gov/drug_disposal/ensuringSAFEUSEOFMEDICINE/safedisposalofmedicines
- www.deadiversion.usdoj.gov/drug_disposal/ensuringSAFEUSEOFMEDICINE/safedisposalofmedicines
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Please consider using/sharing this resource!!!

[Image]
Call for 2019 Robert M. Smith Award Nominees

As you know, each year at the SPA/AAP Winter Meeting, the Robert M. Smith Award is given to recognize an individual who has made outstanding contributions to the field of pediatric anesthesia. The AAP Section on Anesthesiology and Pain Medicine established the Robert M. Smith Award in 1986 to honor Dr. Smith for his contributions in the fields of pediatrics and pediatric anesthesia. Dr. Smith was one of the pioneers in anesthesiology who felt strongly that one of the goals of the field should be to improve techniques and equipment for pediatric patients.

At this time, the AAP Section on Anesthesiology and Pain Medicine Nominations Committee is ready to review nominations for the 2019 Robert M. Smith Award. If you have a potential nominee in mind, please do the following: 1. Complete the online nomination form at https://www.surveymonkey.com/r/WMB97J8; 2. Submit a 2-3 page bio-sketch of the nominee to Jennifer Riefe, Manager, AAP Section on Anesthesiology and Pain Medicine, at jriefe@aap.org. All nominations are due by May 18, 2018.

Thank you for your interest in the Robert M. Smith Award and for your consideration of becoming involved in the nominations process. The AAP Section on Anesthesiology and Pain Medicine Nominations Committee greatly appreciates the feedback of all pediatric anesthesiologists as it annually generates a list of potential individuals to receive this esteemed award.

Robert M. Smith Award Winners
1986: Robert M. Smith
1987: William O. McQuiston
1988: A. W. Conn
1990: Herbert Rackow and Ernest Salanitre
1992: Joseph Marcy
1993: Gordon Jackson-Rees
1994: Margery VanNorden Deming
1995: Leonard Bachman
1996: John J. Downes
1997: C. Ron Stephen
1998: John F. Ryan
1999: George A. Gregory
2000: Not Presented
2001: David Steward
2002: Dolly Hansen
2003: Etsuro K. Motoyama
2004: Theodore Striker
2005: Not Presented
2006: Al Hackel
2007: Josephine Templeton
2008: Federick Berry
2009: Ryan Cook
2010: Juan Gutierrez
2011: Charles Coté
2012: Nishan Goudsouzian
2013: John Christian Abajian
2014: Raafat Hannallah
2015: Charles Lockhart
2016: Lynne Maxwell
2017: Peter Davis
2018: Robert Friesen

Immediate Past Robert M. Smith Award Winner – In Photos

Dr. Peter Davis, 2017 Robert M. Smith Award winner, pictured with Dr. Julie Niezgoda

Dr. Peter Davis accepting the 2017 Robert M. Smith Award

Drs. Frank McGowan and Peter Davis

Drs. Lena Sun, Connie Houck and Peter Davis

Drs. Frank McGowan and Peter Davis

Dr. Peter Davis pictured with many of those who have trained with him and worked alongside him at Children’s Hospital of Pittsburgh through the years
NIH Strengthens Policy On Including Children In Research

AAP News (2/28) reports that recently, when the National Institutes of Health (NIH) “strengthened its policy on including children in research,” the American Academy of Pediatrics “finally saw the fruits of decades of advocacy.” Under the new NIH policy, which goes into effect next year, “for the first time requires researchers to report the ages of participants in clinical research studies funded by the agency.” Clifford Bogue, MD, FAAP, chair of the AAP Committee on Pediatric Research (COPR), emphasized the importance of “age-based data” in pediatric research. Dr. Bogue said, “It will allow us to really have specific data to know how many research dollars are actually going to pediatric research.” What’s more, “we’ll have clear data that show how many children are being included, what studies are including children.” Finally, “it may allow people to aggregate data across multiple studies,” he added.

AAP Issues Guidance on Using the Medical Home to Care for Children with Congenital Heart Disease

Congenital heart disease is the most common birth anomaly. Patients with congenital heart disease have complex health care needs that often must be addressed by the primary care provider in the medical home. To help primary care providers provide the best care possible for these patients, the American Academy of Pediatrics has issued a policy statement, “The Care of Children with Congenital Heart Disease in Their Primary Medical Home,” appearing in the November 2017 issue of Pediatrics. The policy offers primary care providers a “timeline” approach that emphasizes the role of the primary care provider and medical home in the management of patients with congenital heart disease in their various life stages. Some of the recommendations include promoting care coordination and communication between the family, primary care provider and subspecialists - especially during transition from hospital to home or from pediatric to adult care.

Also recommended is facilitating patient access to pediatric subspecialty care and medications, encouraging caregivers to undergo CPR training for patients at increased risk of sudden death and promoting a lifestyle of good nutrition and physical activity in children and adolescents with congenital heart disease.

Choosing Wisely: Some Tests May Be Unnecessary for Young Orthopaedics Patients

In February 2018 the AAP, as part of the Choosing Wisely® campaign, released a list of specific orthopaedic tests and procedures that are commonly ordered but not always necessary when treating children for hip, foot and other musculoskeletal conditions.

The Choosing Wisely recommendations include:

- Do not order a screening hip ultrasound to rule out developmental hip dysplasia or developmental hip location if the baby has no risk factors or physical findings. Both conditions are relatively rare, and universal screening programs have shown a substantial false positive rate, associated with an increase in treatment.
- Do not order radiographs or advise bracing or surgery for a child under age 8 who has a mild in-toeing gait, which usually reflects an ongoing maturation of the skeleton. Monitor the child’s gait at normal well child examinations until age 7 or 8, unless there is severe tripping and falling or asymmetry.
- Do not order custom orthotics or shoe inserts for a child with mild flat feet. If an arch is present when standing on tiptoe, the foot can be managed with observation or over-the-counter orthotics. The orthotic devices to provide support for the foot do not aid in the development of the arch.
- Do not order advanced imaging studies, such as magnetic resonance imaging (MRI) and computerized tomography (CT) for most musculoskeletal conditions until all appropriate clinical laboratory and radiographic examinations have been completed. The MRI exams are costly, frequently require sedation in the young child and may not result in an appropriate interpretation. CT scans deliver a significant dose of radiation.
- Follow-up X-rays for buckle (or torus) fractures of the forearm are unnecessary if the injury is no longer tender or painful. These fractures often do not require a formal cast but instead may be immobilized with a simple wrist brace or removable splint.

The list, Five Things Physicians and Patients Should Question, is available through the Choosing Wisely website. Choosing Wisely® is an initiative of the ABIM Foundation, which seeks to promote conversations between clinicians and patients in choosing care that is supported by evidence; does not duplicate other tests or procedures already received; is free from harm; and truly necessary.

At least 80 medical specialty societies have published more than 500 recommendations of overused tests and treatments as a result of the initiative, launched in 2012.
Opioid Crisis: What Pediatricians Can Do

While pain is a distressing symptom in the treatment of children, opioid misuse is a growing problem in our communities. A new online course, *Chronic Pain and the Opioid Crisis*, aids physicians and other health care providers in a careful examination of their practice for optimal pain management procedures.

Visit PediaLink.org to learn more!
SUNDAY, NOVEMBER 4, 2018  8AM – 12:00PM

JOINT PROGRAM: SECTION ON CRITICAL CARE & SECTION ON ANESTHESIOLOGY AND PAIN MEDICINE  |  Course Co-Directors: Laura Ibsen, MD | Courtney Hardy, MD

ANESTHESIA AND THE ICU: ITS MORE THAN PASSING GAS

There are a number of practice considerations that are shared by pediatric intensivists and pediatric anesthesiologists. This session will delve into several important topics that affect the pediatric patients we share and will allow attendees to broaden their perspective and ask important questions. We will discuss:

- The difficult airway in the ICU from the anesthesiologists perspective
- Issues of acute vs chronic pain management in the ICU setting
- Neurodevelopmental implications of anesthetic agents in the OR and the ICU
- Special considerations of the palliative care patient and implications of DNR status in the perioperative environment

FEATURED FACULTY: TARUN BHALLA, JOSEPH TOBIAS  
NANCY GLASS & LISA WISE-FABEROWSKI
Spotlight on Gun Violence

Guns in Society; Protecting Our Children

Rae Brown, MD, FAAP, Chairperson, AAP Section on Anesthesiology and Pain Medicine (SOA)
Randall Flick, MD, MPH, FAAP, President, Society for Pediatric Anesthesia; Member, AAP SOA

Notable in the current discussions about the presence of guns in America is the lack of a singular, clear voice espousing the protection of children. As pediatric health care providers, recognizing the lack of ability of children to protect themselves, we must raise our voice and seek change. The facts are that when children have guns and are unsupervised, there is often a bad outcome including death and substantial injury, if not by design, then by accident. Children kill other children; children kill themselves, usually accidentally. The argument that guns don’t kill people, people kill people does not hold water. For, if a child did not have a gun, there would be no gunfire and the child would not be injured, or accidentally kill themselves or others. For those that suggest that people that want to kill will find a way, let me remind you that you can run from a knife but not an AR 15. It is a weapon of war. Fewer weapons of war, fewer opportunities for mayhem by children and adults.

It makes no sense in our modern society to have weapons available that we know will kill children, their parents, and their loved ones. It is irrational to expect that children will not hurt themselves when they are given guns or discover them. They will discover them, and many will die. The constitution protects the rights of gun owners? But does not protect the rights of the innocent? How many among us believe that the founding fathers would have allowed for the current torrential flood of guns onto the streets and into homes if they had been aware of what the outcome would be - dead six year olds. Would they have sold guns to the mentally ill, would they have allowed ownership to developing adolescents whose nervous systems cannot understand the implications of their actions? I cannot believe that John Adams, Thomas Jefferson or George Washington would have wanted this. They loved their children and the children of others. They recognized the need to protect the next generation of Americans, and they armed trained soldiers and trained a regulated militia – a militia that is no longer needed to protect our national safety.

The American Academy of Pediatrics is the largest child health advocacy organization in the U.S. We must raise our collective voice; we must protect our children.

Key AAP Resources/Statements on Gun Violence and Prevention

• AAP response to the Parkland, Florida shooting
• AAP Policy: Firearm-Related Injuries Affecting the Pediatric Population
• HealthyChildren.org article: Talking to Children About Tragedies and Other News Events
• AAP Federal Affairs site on Gun Violence Prevention
• Article: How Pediatricians Can Advocate for Children’s Safety in Their Communities
• Fact Sheet: Keeping Children Safe - Preventing Gun Violence
• AAP site: Violence in Hospitals and Inpatient Settings

America’s Frontline Physicians Call on Government to Act on the Public Health Epidemic of Gun Violence

2/16/2018

On February 14, 17 children and adults at Marjory Stoneman Douglas High School in Parkland, Florida, lost their lives at the hands of an individual with an assault weapon. Thousands of children across the country went to school that morning, but some never returned home that afternoon. This senseless loss of life has become all too common in our country, ending lives, shattering families and disrupting the fabric of another community forever branded by this act of violence.

Our organizations (the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Physicians and the American Psychiatric Association) include 450,000 physicians and medical student members. Gun violence is a public health epidemic that is growing in frequency and lethality, and it is taking a toll on our patients. We urge our national leaders to recognize in this moment what the medical community has long understood: we must treat this epidemic no differently than we would any other pervasive threat to public health. We must identify the causes and take evidence-based approaches to prevent future suffering.

Today, our organizations call on the President and the United States Congress to help prevent gun violence in the following ways:
• Label this violence caused by the use of guns a national public health epidemic.
• Fund appropriate research at the Centers for Disease Control and Prevention (CDC) as part of the FY 2018 omnibus spending package.
• Establish constitutionally appropriate restrictions on the manufacturing and sale, for civilian use, of large-capacity magazines and firearms with features designed to increase their rapid and extended killing capacity.

A music concert, shopping mall, church or school, should be places that children and adults can continue to attend without threat or fear of a mass shooting. While these mass shootings command our attention, far too many Americans remain at risk daily for suicide, homicide, and unintentional injury because of the current policy regarding access to guns in the United States. The families of the victims in Parkland and all those whose lives have been impacted by daily acts of gun violence deserve more than our thoughts and prayers. They need action from the highest levels of our government to stop this epidemic of gun violence now.

How Can You Engage as a Pediatric Anesthesiologist and a Member of the AAP?

In the weeks that have transpired between the horrific school shooting that killed 17 students and teachers in Parkland, Florida, a movement has begun to take shape. Leading the way are the student survivors who will not accept the lack of political will that has become all too expected after each recent mass shooting event. They are demanding change from people in power, and they are forcing a long overdue conversation about gun safety.

(Continued on page 12)
Leaning on the Academy’s long history of advocacy to prevent gun violence, we will support these students and raise our own voices to help keep all children safe where they live, learn and play.

Our strategy consists of the following:

- **Speaking up:** Raising our voices as child health experts to help frame the conversation around gun violence as a public health threat to children. This includes advocating for research into the causes and solutions to the gun violence epidemic.
- **Joining in:** Mobilizing all pediatricians, pediatric medical subspecialists and pediatric surgical specialists to come together and speak with one voice to policymakers, the media, parents and the public.
- **Supporting youth and families:** Working to protect the mental health needs of the Parkland survivors and all children who are exposed to the constant threat of gun violence.
- **Pursuing policy change:** Advancing meaningful gun safety legislation at the local, state and federal levels and opposing any efforts that would make children less safe.

So what does that mean for you? Here are **four ways** you can engage in our efforts right now.

- **Participate in March 24 Day of Action.** Attend the march in Washington, DC or cities across the country. Raise awareness in your practice, clinic or hospital about that day.
- **Influence change in your state.** To ensure children are protected, policy change needs to happen at all levels and will require sustained effort. Your help is needed to make a difference. Stay connected to your AAP chapter for current or future related activities. Check in with our state advocacy team for information on related state laws.
- **Learn about our federal policy priorities.** The AAP’s federal advocacy gun violence prevention priorities are here. Sign-in and check this webpage for upcoming opportunities to make your voice heard.
- **Register to vote on November 6.** Visit [www.vote.org](http://www.vote.org) to register and learn more about how to do so early or absentee as needed. Demanding accountability at the ballot box is one of the most effective ways we can help advance policies that prevent gun violence.

Change will not come easily, but with persistence, determination and compassion, together, we can help make it happen, for the Parkland students and for all children whose lives have been impacted by gun violence. We will remain in contact in the days and weeks ahead. On behalf of the board of directors, our CEO, Karen Remley, MD, MBA, MPH, FAAP, and the entire staff, thank you for all you do to help keep children safe.

Sincerely,
Colleen Kraft, MD, FAAP
President, American Academy of Pediatrics

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**Immediate Past Chairperson, Rita Agarwal, Exercises Her Voice on Gun Violence**

Dr. Rita Agarwal, spoke out against gun violence after the Las Vegas mass shooting in an article titled “After Las Vegas: What is the change that needs to occur?” on MedPage Today

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**On Dental Sedation…**

- Ethics Rounds: Death After Pediatric Dental Anesthesia: An Avoidable Tragedy? December 2017
- Concerns Regarding the Single Operator Model of Sedation in Young Children March 2018

**On Spinal Fusion…**

- Pain Is the Greatest Preoperative Concern for Patients and Parents Prior to Posterior Spinal Fusion for Adolescent Idiopathic Scoliosis – January 2018

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**On Intranasal Delivery…**

- Intranasal Ketamine for Procedural Sedation and Analgesia in Children: A Systematic Review – January 2018
- Intranasal Midazolam and Fentanyl for Analgesia and Sedation in Infants in the Neonatal Intensive Care Unit February 2018
- The Evolving Role of Intranasal Dexmedetomidine for Pediatric Procedural Sedation – February 2018

**On the Opioid Crisis…**

- Persistent Opioid Use Among Pediatric Patients After Surgery – January 2018
- Opioids and Operations – January 2018
- Opioid-Related Critical Care Resource Use in US Children’s Hospitals – March 2018
- Calculating the Real Costs of the Opioid Crisis – March 2018

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**Adjuvant Analgesia Reduces Risk of Poor Patient Outcomes in Pediatric Posterior Spinal Fusion** – January 2018

**On Intranasal Ketamine for Procedural Sedation and Analgesia in Children: A Systematic Review** – January 2018

**On Intranasal Midazolam and Fentanyl for Analgesia and Sedation in Infants in the Neonatal Intensive Care Unit** February 2018

**The Evolving Role of Intranasal Dexmedetomidine for Pediatric Procedural Sedation** – February 2018

**Calculating the Real Costs of the Opioid Crisis** – March 2018

**Effect of FDA Investigation on Opioid Prescribing to Children After Tonsillectomy/Adenoidectomy** – December 2017

**Improving the Pain Experience for Children with Limb Injury: A Quality Improvement Initiative** – January 2018

**Using Bedside Tvs to Improve Pediatric Pain Management – Feedback from Nurses and Patients** – January 2018

**Variation in Pediatric Procedural Sedations Across Children’s Hospital Emergency Departments** – January 2018

**The Use of Ketamine in Pediatric Neuropathic Cancer Pain at an Urban Tertiary Care Center** – January 2018

**Using Quality Improvement Methodology to Reduce Sedations for MrI in a Quaternary Care Neonatal Intensive Care Unit** January 2018

**Preparing Your Pediatric Patients and Their Families for the Operating Room: Reducing Fear of the Unknown** – January 2018

**Improving Interdepartmental Handoff Communication Between the Medical Anesthesia, and Surgical Teams to Prevent Patient Harm - A Quality Improvement Study** – January 2018
As many of you know, there are currently 52 Sections within the American Academy of Pediatrics representing members who share a pediatric subspecialty, surgical specialty, special area of interest, or stage of life. Sections are formed to cultivate ideas and develop programs within their subspecialty or special interest that improve the care of infants, children, adolescents, and young adults. There are currently 10 surgical specialty sections: Anesthesiology and Pain Medicine, Neurosurgery, Ophthalmology, Oral Health, Orthopaedics, Otolaryngology and Head & Neck Surgery, Plastic Surgery, Radiology, Surgery and Urology. The Chairs of each of these Sections make up the AAP’s Surgical Advisory Panel (SAP) which meets twice a year - in March at the Annual Leadership Forum and at the AAP’s National Conference and Exhibition (NCE) in the fall.

After serving as a SAP member during my time as SOA Chair, I was fortunate to be elected to serve as the Chair of the Surgical Advisory Panel in 2015 and represent all of the surgical specialty sections to the AAP Board of Directors and Academy leadership. In March, I will be completing my first term as the Chair of SAP and am hoping to serve a second 3-year term after the upcoming election being held just before the Annual Leadership Forum in March. As part of my duties as SAP Chair, I attend the 3 AAP Board Meetings in January, May and October. Described below are some recent AAP activities and initiatives that will likely have a significant impact on pediatric anesthesiologists and all surgical specialists in the Academy.

**Strategic Plan Update and Full Board Representation by Surgical Specialist**

As mentioned in the Fall SOA Newsletter, a comprehensive 5-year strategic plan for the organization was developed as part of a major restructuring of the AAP under the new CEO, Karen Remley, MD, MBA, MPH. The AAP Board of Directors worked for 18 months to develop a new approach to governance of the organization and this included some important developments for surgical specialists, specifically in the area of Academy leadership. The full Strategic Plan can be downloaded here: https://www.aap.org/en-us/Documents/AAP_Strategic_Plan.pdf.

An important part of the plan included Objective 3.1. Diversity representation on the Academy’s board of directors beyond geographic districts to represent a broader array of Academy constituencies. I am excited to announce that at the November 2017 Board of Directors meeting, a bylaw change was approved that would:

*Expand the AAP Board of Directors with three additional seats for elected, at-large directors with leadership experience from committees, councils and sections. One of the 3 at-large seats will be a medical subspecialist and one will be a surgical specialist.*

For the full AAP News article on this topic, please see page 15 of this newsletter.

There will be a referendum to amend the bylaws to be voted on by the full AAP membership in the Fall 2018 election. If this is passed, then the process for selecting candidates for these at-large seats will be implemented in the Spring of 2019 and the candidates will appear on the ballot in the fall of 2019. What this means is that there will very likely be a surgical specialist on the AAP Board of Directors in January 2020!

**Headquarters of the Future**

I was fortunate to be able to attend the official opening ceremonies of the AAP Headquarters of the Future in Itasca, Illinois in January 2018. It is a beautiful, sun-filled facility 10 miles from O’Hare International Airport with 183,000 square feet of space and state-of-the-art teleconferencing facilities that will make it possible for more people to participate even when they can’t come in person. The building has been funded largely by contributions from members and as part of this, the Surgical Advisory Panel has launched a campaign to fund a conference room in the facility. We have currently reached approximately 60% of our $100,000 goal. The plan is to make this a “surgical specialty” conference room and decorate it with pediatric anesthesia and surgical memorabilia. Our hope is that we can use this conference room for meetings and teleconferences throughout the year and also raise our presence within the Academy.

More to come on this in the next few months…

**Collaborative Perioperative Initiatives**

One of the unique aspects of the AAP is the ability of diverse groups of pediatric professionals to work together to achieve collaborative goals. As part of this, SAP has created 3 working Task Forces to tackle shared issues that affect all of the surgical specialists.

**2018 SAP Task Forces**

- **Surgical Section Membership Task Force** – The membership chairs of all of the surgical sections in SAP have formed a task force to better define membership value and explore membership options. Surgical specialists see particular value in subspecialty-specific advocacy activities, authorship and publishing opportunities, efforts to highlight pediatric surgeons, dentists and anesthesiologists in the AAP via the physician finder tool on healthychildren.org and other collaborative opportunities with pediatric colleagues. There is also interest in exploring new membership models such as combined dues models with sister societies, specific surgical specialist membership with targeted benefits and opportunities for surgical group practices or departments to develop their own Institutional Memberships. The Task Force is currently working on developing a list to present to the Board of Directors at the Annual Leadership Forum in March defining Member Value and Preferred membership packages for surgical specialists.

- **Transitions of Care Task Force** - There is a growing cohort of patients needing structured and anticipatory guidance on long-term care for their surgically-corrected anomalies. The pediatric surgical community needs to better define the need and develop guidelines for transitional care plans (with input from all stakeholders), better understand the workforce, and establish the value of formalizing the transition of care. Dr. David Rothstein (surgeon) is leading this effort along with a task force of other surgical section representatives. Dr. Rothstein and Dr. Houck met with Dr. (Continued on page 14)
Patience White (Co-Project Director of “Got Transitions”) during the 2017 NCE to discuss opportunities for collaboration and to discuss best practices to move this initiative forward.

• **Optimal Timing of Pediatric Surgery Task Force** – In response to the FDA warning about potential neurobehavioral toxicity of general anesthetic and sedation drugs, SAP has developed this task force to develop a policy statement describing optimal timing for specific surgical procedures. An intent has been prepared and work continues on development and refinement of this statement.

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**Other Ongoing Initiatives**

• **Perioperative Safety and Quality** – The AAP-endorsed American College of Surgeons Children’s Surgery Verification Quality Improvement Program (ACS CSV) has continued to expand. Currently, 8 pediatric surgical programs are ACS CSV-verified and 111 programs have joined Pediatric NSQIP and are in various stages of preparation for verification. The Wake-Up Safe (WUS) initiative is now working with the ACS NSQIP Data Safety Committee to expand nationwide collaborative data collection and tracking of perioperative events. The AAP has also begun a Neonatal ICU Verification program modeled after ACS CSV. These two programs are working collaboratively to improve perioperative safety for our most vulnerable infants by setting nationwide standards for care. More information about the ACS CSV program can be found at: [https://www.facs.org/quality-programs/childrens-surgery/childrens-surgery-verification](https://www.facs.org/quality-programs/childrens-surgery/childrens-surgery-verification)

Information about the NICU verification program can be found at: [https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/nicuverification/Pages/default.aspx](https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/nicuverification/Pages/default.aspx)

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**2018-19 Section Election**

We are pleased to present Dr. Christina Diaz and Dr. Lisa Wise-Faberowski as the candidates (unopposed) for two open positions on the AAP Section on Anesthesiology and Pain Medicine Executive Committee. If confirmed by our Section membership during the election this month, Drs. Diaz and Wise-Faberowski will join the Section Executive Committee in November 2018.

Christina Diaz, MD, FASA FAAP
After graduating from the University of Denver and receiving my Medical Doctorate from Baylor College of Medicine in Texas, I completed my Anesthesiology Residency and Pediatric Anesthesiology Fellowship at the Medical College of Wisconsin. I currently serve as Associate Professor, Assistant Program Director and Children’s Hospital of Wisconsin (CHW) Site Director for the residency program as well as Site Director for the Anesthesia Assistant program. As a member of the Acute Pain Service I train our pediatric anesthesia fellows in perioperative pain control. My academic interest is in education with a focus on the use of simulation for education. I run the pediatric anesthesia fellowship simulation program at our institution, and together with an ENT colleague I have established a joint surgical – anesthesia simulation workshop that practices rigid bronchoscopy in a team approach. A colleague and I also mentor approximately 30 residents, fellows, and medical students annually to compete at the Midwest Anesthesia Resident Conference with significant trainee success.

I believe it is important to advocate for my patients, my specialty, and the future landscape of healthcare. Therefore, I am an active member of the American Society of Anesthesiologists (ASA) and the Society for Pediatric Anesthesia (SPA), have served in the ASA House of Delegates for the past 5 years, have served on the Committee on Pediatric Anesthesia, chaired the SPA Annual Meeting in 2016, co-chaired the Wisconsin Society of Anesthesia Annual Meeting (2014), participate annually at Doctor’s Day Advocacy at the State Capitol, and have been a Wisconsin Society of Anesthesiology Board Member since 2012. I wish to continue to advocate for my pediatric patients and serve my specialty, and I look forward to working within the AAP Section on Anesthesiology and Pain Medicine.

Lisa Wise-Faberowski, MD, FAAP
Dr. Lisa Wise-Faberowski, Assistant Professor of Anesthesiology, Perioperative and Pain Medicine, Stanford University; I began my journey with training and board certification in pediatrics in the early 1990’s. I completed my anesthesia training and research fellowship training in 1997 with board certification in anesthesiology. I continued with training and board certification in pediatric critical care medicine and pediatric anesthesia. So through and through I am a pediatrician, but also an anesthesiologist.

It would be an honor to serve for an organization that has supported me throughout my career. The AAP Section on Anesthesiology and Pain Medicine has supported my research endeavors in pediatric neuroprotection and anesthetic neurotoxicity through the John J Downes award at two of the Society for Pediatric Anesthesia annual meetings. Amazingly, I received one of the awards after the birth of my twins Alyssa and Cooper.

As a mother of four children and as a pediatrician and anesthesiologist, I understand the importance of accepting the life of one’s child into my hands in providing anesthetic care. Our children are our heart and soul, and an irreplaceable component of our life. So it is with honor and a passion for the best care of our children in anesthesia and in life that I would like to serve as an Executive Committee member for the American Academy of Pediatrics-Section on Anesthesiology and Pain Medicine.

On March 1st all members of the Section on Anesthesiology and Pain Medicine received a ballot to vote for three (3) positions on the SOA Executive Committee - for two open Executive Committee positions as well as for the Executive Committee member position currently held by Dr. Mary Landrigan-Ossar, who is running unopposed as the incumbent. The voting period is from March 1 to March 30.

Please go to [https://forms.aap.org/vote](https://forms.aap.org/vote) to view the online ballot. You will need your AAP ID and password to log in. If you’ve signed up for healthychildren.org you will need to use your email address.

Please note, if you are a member of more than one Council and/or Section, you will only see ballots for the council(s) and section(s) conducting elections this year.
AAP Board takes bold steps: adds 3 director seats, clinical data registry
by Anne Hegland, Editor-in-Chief

Now implementing its five-year strategic plan, the AAP Board of Directors took steps during its meeting Nov. 2-3 to diversify board representation and build a clinical child health data registry.

Three new seats will be added to the AAP Board of Directors under a proposal approved by the board and to be voted upon by the full membership. While details of the process have yet to be defined, the board agreed that one seat would be filled by a medical specialist and another by a surgical specialist.

The proposal is in furtherance of a goal in the 2017-'18 AAP Strategic Plan calling on the Academy to diversify representation on its Board of Directors beyond geographic districts to include a broader array of the organization's constituencies.

During the fall 2018 national election, members will vote on the proposal to amend the organization's bylaws and add three seats to the board, which now has 10 members. If the referendum question passes, three at-large candidates will be selected in early 2019 and voted on during the national election in October. Newly-elected at-large board members will be seated in January 2020.

In the meantime, board members will be soliciting feedback from stakeholders to help develop the process to fill the three positions.

AAP President Fernando Stein, M.D., FAAP, explained that after much discussion and reflection, the board reached two conclusions. "First and foremost, they affirmed the current district-based representation structure of the board successfully serves the AAP's mission and members, and maintains a close connection between the organization's elected leaders and membership. The district-based, geographic representation system should be retained."

Secondly, Dr. Stein explained, "The number and scope of the AAP's committees, councils and sections has grown to respond to the changing needs of the profession and of children and families. The work of the board would be enriched by adding new, at-large directors that have deeper links with the AAP's committees, councils and sections and connections to medical subspecialists and surgical specialists."

Establish clinical data registry

The Academy has set sail to be the first entity to collect, store and analyze health data on all U.S. children. The board agreed to commit $583,000 in resources from the Tomorrow's Children Endowment to begin development of a child health clinical data registry, which is expected to unfold over five years. This unprecedented initiative, called Clinical Health Information and Longitudinal Data Registry (CHILD), is the outgrowth of two strategic plan objectives:

- Use data and metrics to develop and prioritize areas of need for child health policies.
- Provide state-of-the-art pediatric practice information in the context of a changing industry and professional landscape.
News Articles

Data would be captured through electronic health records, integrated health care systems, payers and existing pediatric disease registries. Data elements would include well-child and sick visits, chronic disease diagnosis and management, specialty care, and developmental and behavioral care. The registry also would include a patient portal to allow parents and patients to input data, while alleviating complications surrounding privacy laws.

Christoph U. Lehmann, M.D., FAAP, medical director of the AAP Child Health Informatics Center, and professor of pediatrics and biomedical informatics, Department of Medicine, Vanderbilt University School of Medicine, presented project details to the board, including the following primary goals:

- Create substantial improvements in child health and well-being.
- Accelerate advances in child health.
- Improve outcomes for children using data.
- Demonstrate the trajectory of child health through adulthood.

Among the benefits of this registry, Dr. Lehmann said, are tracking childhood health and illness trends, which would help draw conclusions on a number of areas, including gaps in care, treatment options and regional variations in care. The data also will help inform the creation of AAP guidelines and policies, and provide guidance to payers.

Members could use the data to help create reports for quality improvement projects, as well as for meaningful use and Maintenance of Certification, Dr. Lehmann said.

Emphasizing data privacy and security, he said pediatricians will own their data and give permission for data to be distributed and reported. Protected health information will be stored separately from clinical data. Access to data will be tiered based on permission level.

A work group will be established to provide clinical direction for registry development, assist in the development of a sound business plan and define the purpose of the registry.

Diversity and inclusion

The Task Force on Diversity and Inclusion (D&I) submitted its final recommendations to the Board of Directors. Co-chairs Danielle Laraque-Arena, M.D., FAAP, and DeWayne Pursley, M.D., M.P.H., FAAP, presented four recommendations and related action steps, which contribute to the guiding principle that the Academy's commitment to diversity and inclusion should permeate all aspects of organizational functioning and be collaborative, explicit and nationally visible.
Those recommendations are:

1. Create an enduring structure addressing D&I within the Academy to: a) develop and advance initiatives around D&I and b) provide guidance, coordination and oversight related to these activities.
2. Encourage, develop and communicate D&I initiatives for and with AAP membership.
3. Explicitly promote and sustain a diverse pool of leaders throughout the AAP leadership structure.
4. Track and evaluate AAP actions and outcomes related to diversity and inclusion to foster an environment of continuous reflection and improvement.

The task force requested that the Board of Directors seek comment on these recommendations from a variety of internal stakeholders and external partners before making them final.

**Membership committee sunset**

The establishment of a committee of the Board of Directors focusing on member value and engagement led to a vote to sunset the Committee on Membership, effective June 30, 2018. The board committee will continue to reach out to chapters, chapter executive directors, early career physicians, medical subspecialists, surgical

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**Resource**

- AAP Diversity and Inclusion Statement

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**New AAP Academic and Subspecialty Advocacy Report**


- The Report contains updates on the following topics:
- Children’s Health Insurance Program
- Policies to Erect Barriers to Medicaid Eligibility
- Current State of Health Reform
- Medical Foods Coverage
- ACE Kids Act
- Support for Pediatric Subspecialists
- Children’s Hospital GME Funding and Reauthorization
- Student Loan Reform and Public Service Loan Forgiveness
- Travel Ban and the Medical Workforce
- Deferred Action for Childhood Arrivals
- Medicaid Payment Equity
- FDA Reauthorization Act
- Orphan Loophole
- Over-the-Counter Drug Reform
- Pediatric Device Consortia Program Appropriations
- Opioids and Children
- Pediatric Labeling for Butrans
- FDA Approves Label Changes for Use of General Anesthetic and Sedation in Young Children
- Inclusion of Children in NIH-Funded Research
- National Institutes of Health Appropriations
- Gun Violence Research and Prevention
- All of Us Research Program
- Environmental influences on Child Health Outcomes (ECHO)
- Cancer “Moonshot” Initiative
- Indirect Costs in NIH Grants
- Budget and Appropriations
- Emergency Medical Services for Children Program
- Federal Aviation Administration Emergency Medical Kits
- Protecting Patient Access to Emergency Medications Act
- Grassroots Advocacy: AAP Key Contact Program
- FederalAdvocacy.aap.org: Dept. of Federal Affairs Online Resource Center
- Engage with AAP on Social Media
Codeine, Tramadol, Opioids, and Neurotoxicity
The FDA Responds to Multiple Public Health Issues
Raeford E. Brown, Jr., M.D., FAAP Chairperson, Section on Anesthesiology and Pain Medicine

Within the last two years the FDA has confronted multiple public health issues of interest to anesthesiologists. Some of these problems, such as the safety profile of codeine, have festered for years in the public and professional psyche; some, such as the ongoing discussions about possible neurotoxicity in the developing central nervous system in a broad class of drugs related to the practice of anesthesiology, represent newer issues that have come to our consciousness relatively recently. The decision-making process of the Agency is not always transparent and findings, though based in the main on science and advice from countless outside experts, seldom provide sufficient published background for complete understanding. Occasionally findings by the Agency produce frank consternation among even the well informed. In this article, based on personal experience, the aim is to provide information relating to some recent findings, to clarify the authority of the FDA to make decisions, and to provide an assessment of the reasoning that was used in making some recent findings.

The regulatory authority of the Agency is based primarily on the federal Food Drug and Cosmetic Act of 1938, which has been amended by Congress numerous times since its initial passage. It is the responsibility of the Agency to interpret these laws based on their best understanding of current medical knowledge. It is not a revelation that the dynamic nature of the practice of medicine often outstrips the ability of the Congress to provide FDA with specific authority to manage rapidly evolving public health problems. An example is the lack of enforcement authority to require drug sponsors to provide post marketing information on Abuse Deterrent Formulations (ADFs) of opioids, though this requirement is clearly spelled out in the original agreement between the FDA and the drug sponsor. In some instances, the authority of the Agency is undercut by political pressures, many times from the pharmaceutical industry, which spends millions of dollars a year to change the behavior and thinking of legislators. These pressures are frequently passed down to individuals at the Agency that are expected to base decision making on verifiable science.

Codeine
Restrictions on codeine by the Agency reflect discussions with the anesthesiology and pediatrics professional communities ongoing since December 2015. Similar restrictions on tramadol were also announced to the consternation of some pediatric clinicians. In December 2015, an Advisory Committee meeting involving elements of the pediatric and anesthesiology community met for two days to discuss codeine use as an analgesic or antitussive agent in infants and children. Collectively, pediatricians and anesthesiologists had been lobbying the Agency for some years to restrict the sale of codeine in the United States. The FDA’s data had revealed 16 deaths associated with the ingestion of codeine by children, or the infants of breast-feeding mothers with many more episodes of documented near misses. The suggestion that these numbers likely represented a significant under count and that the risks outweighed the need for an analgesic compound that produced such genetic variability in its metabolism led many experts to question the advisability of codeine remaining on the market, at least for infants and children. Many from the pediatric community further questioned codeine’s use as a cough suppressant, citing studies that have demonstrated a lack of efficacy, especially in infants.

This large group advised the Agency that codeine should be significantly restricted, especially in infants and the mothers of breast-feeding infants. Many on the panel opined that codeine would continue to be used in children unless it was taken off of the market altogether. Also, more than 25 states allow for the sale of combination compounds containing codeine over the counter. These formulations have low concentrations of codeine, but are allowed to be marketed under the FDA over-the-counter monograph based on a decades old determination that the drug was safe and effective. To restrict prescription codeine without acting on the nonprescription compound seemed unreasonable.

Eighteen months after this meeting, and with continued pressure from the AAP and the Society for Pediatric Anesthesiology, the Agency restricted the use of codeine and tramadol in children under the age of 12. These actions were taken in addition to the boxed warning to codeine’s label that has been in place since 2013. But why tramadol?

Tramadol is approved in the U.S. for the treatment of pain in adults but not children. The pathways that affect the breakdown of codeine in the body are similar to those observed with tramadol. Both utilize cytochrome CYP2D6 and population studies suggest that tramadol has fast, slow, and no genetic variants yielding high, intermediate, and no presence of the active breakdown product – morphine for codeine, and O-desmethyltramadol for tramadol. The unexpected high levels of active metabolites place children, and especially infants at risk for respiratory compromise. The Agency identified twelve cases of severe respiratory disturbance in its data set. Policy makers feared that an unintended result of further restrictions on codeine would have the unintended consequence of inviting clinicians to switch to tramadol, with resulting breathing issues and deaths.

Clinicians have not accepted the policy relating to tramadol with the support seen with codeine. Many worry that there are very few oral analgesic agents that provide moderate analgesia without the side effect profile of NSAIDS. Some are concerned that prescribing oral hydrocodone or oxycodone sends an unintended message about opioid use and thus increases risk to the larger population. It is my opinion that this issue has not played out completely.

Abuse Deterrent Formulations of Opioids
Abuse deterrent formulations (ADFs) are opioids that have been manufactured with increasingly sophisticated technologies that would be expected to reduce the risk that users can alter the compound for purposes of intravenous injection or inhalation. ADFs are not less addictive that the parent compound. ADFs do not prevent abusers from using the most common form of abuse, the oral route. Patients that become addicted thru the oral intake of progressively larger quantities of oxycodone would be expected to similarly become tolerant and then addicted to the ADF formulation.

The use and misuse of opioids follows a pattern that usually begins with the oral intake of progressively larger quantities of the drug. The ADF compound can be ingested in large quantities if available to

(Continued on page 19)
the patient. As patients develop tolerance, and in their desire to obtain more rapid and intense effect, many migrate first to inhalation of the drug, followed by injection. Most of the deaths associated with opioid abuse follow injection or snorting, and the purpose of the ADF formulation is to decrease the likelihood of this progression. The ADF formulations of prescription opioids can contain the equivalent of up to 80 mg of oxycodone or other agents, making them a significant target for the kitchen chemist. Remember: ADFs don’t prevent oral opioid abuse no do they have any effect on the development of addiction.

Recently, independent reports have begun to call to question the efficacy of ADFs in reducing the rate of addiction or the mortality rate. Issues of increased cost for addicted subjects may have driven a significant population to illicit drugs such as heroin and fentanyl. The Agency convened the Advisory Committee on Anesthetic and Analgesic Drug Products in April 2017 in order to respond to post-marketing data suggesting that aspects of one ADF formulation of oxymorphone was likely responsible for a significant rise in mortality and in hepatitis c and AIDS infections.

These observations of the questionable safety of oxymorphone in this particular ADF were not seen in the testing of the drug in the lead up to its marketing, and represent a vivid example of the need to continue to closely examine the behavior of opioids after they are on the market. Unfortunately, drug sponsors have failed to honor agreements with the FDA to provide data for post-market analysis, and enforcement authority for these agreements is lacking. The Agency responded to the Advisory Committee by asking that the drug be removed from the market.

CNS toxicity of anesthetic agents in the developing brain

In December of 2016, the FDA, without discussion, released a Medwatch Warning concerning the use of general anesthetic agents in infants and children less than age three for periods greater than three hours, or repeatedly until after age three. In addition, the Agency cautioned medical professionals about possible risks to the development of the central nervous system of the fetus when general anesthetic agents were administered to pregnant females during the third trimester. These warnings did not include a Black Box Warning about any of the agents, but did advise manufacturers to provide labeling on each of the agents consistent with the warning. These findings apparently had been under discussion within the Agency for many months and was not based on any new or unique information concerning the toxicities of the agents. The wording of the advisory, “out of an abundance of caution”, recognized that no human studies provided incontrovertible evidence of causation of purported toxicities; the preponderance of information from pathological and developmental studies in a variety of animal species revealing accelerated apoptosis and the suggestion of development delay forced the FDA to advise all clinicians about the importance of enhanced discussions of the need for surgical or diagnostic procedures requiring long anesthetics in infants up to age three. The SPA, in concert with the American Academy of Pediatrics Section on Anesthesiology and Pain Medicine was instrumental in responding to this statement with press releases, articles, and interviews with the press focusing on the fundamental safety of Pediatric Anesthesiology in 2017.

This commentary does not reflect the views or opinions of the FDA or the AAP.

WELCOME NEW MEMBERS!!

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<tr>
<th>Name</th>
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<td>Victoria Bradford</td>
<td>Lexington, Kentucky</td>
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<td>Jane Brumbaugh</td>
<td>Rochester, Minnesota</td>
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<td>Destiny Chau</td>
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<td>Benjamin Ekstrom</td>
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<td>Morgantown, Pennsylvania</td>
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Young Physicians Leadership Alliance (YPLA) Application

The AAP’s Section on Early Career Physicians (SOECP) is pleased to announce the call for applications to our next Young Physicians’ Leadership Alliance (YPLA) training, which will again be held just prior to the AAP National Conference & Exhibition this November. This 3-year training program is designed to develop leaders and build a leadership community amongst early career pediatricians and pediatric subspecialists. The program will include the sharing of leadership principles, behaviors, and tools that can benefit early career physicians in achieving their personal and professional objectives. Click here for more information and to access the application. The deadline for submissions is Friday, April 20, 2018.
Section Wins Award for Educational Excellence @ ALF

On Friday, March 16th, 2018, the Section was presented with an award for Outstanding Service in Educational Excellence at the AAP’s Annual Leadership Forum (ALF). Each year at the ALF the Section Forum Management Committee recognizes Sections for their outstanding contributions in the following categories: advocacy, communication & collaboration, educational excellence, innovation, member recruitment, unsung heroes and young member involvement. The award for educational excellence recognizes one section annually for innovative contributions to the education of pediatric health care providers that have a positive impact on the health and well-being of children and adolescents.

The SOA was honored for exhibiting notable educational excellence in its recent activities and accomplishments, advancing the management of perioperative care and pain control in children. With the nationwide opioid crisis in full swing as well as ongoing controversy over the safety of sedative/anesthetic drugs in young children and the safety of pediatric sedation in dental offices, it was noted that the SOA has stepped up to take a leading educational role within the AAP on these topics. Myriad educational methods were employed throughout 2017 to reach healthcare providers: policy statements, manuals, news articles and other publications, webinars, online CME modules, and live educational events. In addition, the SOA has been active in developing/distributing educational materials for parents through AAP’s Pediatric Patient Education online service, HealthyChildren.org, and by utilizing exhibit booths at live meetings.

Drs. Rae Brown, Connie Houck, and Anita Honkanen attended the ALF, along with Section Manager, Jen Riefe, and were pleased to be there for the presentation of the award by Dr. Ann Stark, Chair of the AAP’s Section Forum Management Committee. A hearty congratulations goes out to Dr. Rita Agarwal, Immediate Past Chairperson, who was responsible for leading much of the SOA work honored during the ALF!

2018 AAP National Conference and Exhibition - Call for Abstracts Now Open!

The call for abstracts for the 2018 AAP National Conference and Exhibition (NCE) is now open. During the NCE, AAP Council and Section programs cover clinical matters or research related to subspecialty or special interest areas. Submissions by AAP members, nonmembers, and by health professionals in any field are accepted. Accepted abstracts are generally presented as posters at the NCE, although there are some opportunities for oral abstract presentations as well. For more information, please visit: https://www.aap.org/en-us/continuing-medical-education/Pages/Abstracts.aspx. The deadline to submit abstracts for the 2018 meeting is April 13, 2018.

Note that abstracts are presented during section-specific programming at the NCE. The Sections accepting abstract submissions for the 2018 NCE are listed below:

- Council on Child Abuse and Neglect
- Council on Clinical Information Technology
- Council on Early Childhood
- Council on Foster Care, Adoption, and Kinship Care
- Council on Injury Violence, and Poison Prevention
- Council on Quality Improvement and Patient Safety
- Council on School Health
- Council on Sports Medicine and Fitness
- Innovations in Obesity Prevention, Assessment, and Treatment Forum
- Pediatrics for the 21st Century (Peds 21): Leverage New Technologies to Transform Child Health
- Section on Advances in Therapeutics and Technology
- Section on Breastfeeding
- Section on Cardiology and Cardiac Surgery
- Section on Critical Care Abstracts Program
- Section on Emergency Medicine
- Section on Hospice and Palliative Medicine
- Section on Hospital Medicine
- Section on Integrative Medicine
- Section on International Child Health
- Section on International Medical Graduates Joint Program
- Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness
- Section on Medicine-Pediatrics
- Section on Neonatal-Perinatal Medicine
- Section on Obesity
- Section on Oral Health
- Section on Orthopedics
- Section on Pediatric Trainees
- Section on Surgery
- Section on Tobacco Control
- Section on Transport Medicine
- Section on Uniformed Services

AAP Releases Summary of Its Activities to Address the Opioid Crisis

At the Annual Leadership Forum in March, the AAP made available to members a summary of its activities to address the opioid crisis. Among other things, the document includes an overview of recent policy work, provider education, and federal advocacy on opioids and children. It is available online at: http://downloads.aap.org/DOPCSP/AAP Opioid Activities.pdf
AAP child health advocacy reaches beyond U.S. borders

by Trisha Korioth, Staff Writer

AAP policies and goals reach beyond U.S. borders. How much do you know about the Academy's involvement in global advocacy? Test your knowledge here!

Q: How do AAP policies help shape world health policy decisions?

A: The U.S. government often turns to the Academy to inform its negotiations with the World Health Assembly and United Nations (U.N.) on matters of pediatric and child health policy. As a voting member, the U.S. government has included the Academy as part of its delegation to the U.N., World Trade Organization and other forums. The World Health Organization (WHO) and U.N. support and guide countries to develop their own systems of care. In turn, the Academy works with pediatric societies in other countries on unified fronts that help ensure children's needs are reflected in what the U.N. and WHO are hearing from member states. The relationships and learning are reciprocal.

Stephen D. Warrick, M.D., FAAP (left), and AAP President Colleen A. Kraft, M.D., FAAP meet with Rep. Steve Chabot (R-Ohio) as part of last year's global health advocacy track at the AAP Legislative Conference.

Q: What unique attribute does the Academy contribute to the WHO, U.N. and U.S. government entities working on children's global health issues?

A: Pediatricians care for and hear children's and adolescents' needs directly. The Academy works to ensure the voices of pediatricians and their patients are elevated and represented.
Q: What are the Academy's global advocacy priorities, and do they relate to what's happening in the U.S.?

A: All of the Academy's global priorities are based on its policies and programs, and address the leading causes of child mortality and morbidity. They focus on providing equitable access to care for children and adolescents in low-resource settings. Many of the goals parallel the Academy's goals for U.S. children's health. They include:

- maternal and child survival;
- holistic child health, including infectious diseases, noncommunicable diseases, nutrition as well as supporting the needs of health systems and health care workers;
- adolescent health, including reproductive health, family planning, nutrition and noncommunicable diseases; and
- early brain and child development, including toxic stress and creating supportive and safe environments.

Q: Does the Section on International Child Health (SOICH) write policy statements?

A: The section co-authored its first policy statement, *Global Human Trafficking and Child Victimization* (https://doi.org/10.1542/peds.2017-3138), last year. SOICH has other statements in progress, including one about children afflicted by armed conflict. Ideas have stemmed from member input at the Annual Leadership Forum as well as feedback from other section, council and committee members involved in international initiatives.

Resources

- SOICH webpage
- AAP global child health priorities
- AAP News story "Become a global child health advocate"
- Additional AAP News AAP Abroad columns