Happy Spring for those of you who don’t have snow on the ground!

I am happy to say that we as a section had many activities going on this winter, and it is as busy a time as ever on the national Med-Peds scene.

Our section executive committee met at the annual ACP meeting last week in San Diego, giving us the opportunity to discuss issues of great importance to the Med-Peds community. We discussed how Maintenance of Certification continues to leave most of us flummoxed trying to keep up with the rapid changes from both Boards. Of recent note for MOC is that both the ABIM and ABP are trying to transition from large, high-stakes testing every 10 years to systems where there is ongoing evaluation at discrete periods of time either every few months or every 2 years. The ABP is piloting a trial program, and the ABIM (http://transforming.abim.org/abim-increases-physician-choice-with-new-assessment-option/) has approved an every two year knowledge check-in. It was the consensus of the committee that this represents a positive change from a learning perspective to allow a shorter open book evaluation during a shorter interval. For those of us in practice, the ABP also made some changes that may help the process of performing QI and getting part 4 credit, which can be found on their website. We also discussed the new proposal for residency regulations and requirement and will work with the Med-Peds Program Director’s Association to discuss how that will affect training. Lastly, we are thankful to Sam Borden for setting up our new Subcommittee on Educational Program Planning, which I thank over 25 of you for volunteering to work to plan CME activities at our annual meetings.
Letter from the Chair of the Med-Peds Section (continued from page 1)

This winter we were fortunate enough to collaborate with the AAP Section on Adolescent Medicine to hold a joint CME course in Anaheim. The conference, entitled 2017 Practical Care of the Adolescent and Young Adult, featured many Med-Peds speakers and attendees and was by all accounts a very successful CME conference for us as a Med-Peds community. This is one of the few times that this section has co-sponsored a CME course and we are very grateful for the work by Sam Borden, Katy Lerman and Tommy Cross as well as the Section on Adolescent Medicine for working to pull this off.

I also want to thank all of you who were able to attend the Med-Peds reception at the annual ACP meeting on March 30 in San Diego. We were truly honored that the executive leadership, including ACP CEO Darilyn Moyer, M.D., Chair of the Board of Regents Thomas Tape, MD, and President Nitin Damle, MD, were able to attend our reception, and thanks to Dr. Moyer for cutting a large cake in our honor for our 50th anniversary. I would love to see all of you at the reception we are planning in September at the AAP meeting in Chicago, this will be the "big event" to celebrate the 50th anniversary of us as a specialty. Being held in conjunction with NMPRA and MPPDA, it will be a great opportunity to mingle and network with Med-Peds colleagues from across the country.

Thanks,

Mike Donnelly, MD, FAAP, FACP
Chair, Med-Peds Section, American Academy of Pediatrics
Letter from the MPPDA President

Looking Back, Looking In, Looking Forward

As Med-Peds celebrates our 50 years as a combined specialty, more than 160 people attended the national meeting of the Med Peds Program Directors Association in Anaheim, California. The theme of the meeting was "Looking back, looking in, looking forward." Dale Newton, along with Allen Friedland, gave the keynote address as our "birth story." Old documents were shared cataloging our origin. We "looked in" by establishing a system of regional meetings, practicing meditation, and addressing racial bias. We "looked forward" reading letters of support from national organizations - the ABP, ABIM, AAIM, APDIM.

To celebrate, in keeping with our grand traditions, we had a rousing reception featuring a karaoke band. Onwards to the next 50 years!

Benjamin Doolittle, MD

Save the Date

American Academy of Pediatrics National Conference
September 16-19, 2017, Chicago, IL
http://aapexperience.org/

American College of Physicians
April 19-21, 2018, New Orleans, LA
https://www.acponline.org/meetings-courses
**High Value Care: New Transitions of Care Toolkit**

A new Transitions of Care Toolkit designed to assist physicians in transitioning patients from pediatric care to an adult primary or specialty setting of care is now available. Developed by the American College of Physicians (ACP) Council of Subspecialty Societies, with participation from the American Academy of Pediatrics (AAP), multiple medical specialty groups and patient advocacy organizations, the toolkit contains disease/condition-specific tools developed to assist physicians in transitioning young adults with chronic diseases/conditions into adult care settings. Based on the clinical report, “Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home,” from the AAP, ACP, and American Academy of Family Physicians, the National Health Care Transition Center/Got Transition developed an evidence-informed model, the Six Core Elements of Health Care Transition, which includes free sample tools clinicians can download and implement in their offices. These core elements were used as a basis for the development of the Transitions of Care Toolkit. Click here for more information and to access the Transitions of Care Toolkit.

**A Toolkit to Help Pennsylvania Youth in Foster Care and the Juvenile Justice System Prepare for IEP Meetings**

Developing an IEP Transition Plan: http://jlc.org/resources/publications/developing-iep-transition-plan

The purpose of this Toolkit is to help transition-age youth and their advocates prepare for IEP meetings and develop strong IEP Transition Plans. Although this Toolkit is aimed at youth in foster care or the juvenile justice system, who often lack engaged adults to advocate for them at IEP meetings, it can be used by any teenager receiving special education. The Toolkit helps these youth and their advocates actively engage in the transition planning process by allowing them to set goals, identify barriers, and brainstorm possible services in advance of the IEP meeting.

**Check out these two articles!**

Young Adults With Chronic Illness: How Can We Improve Transitions to Adult Care? http://pediatrics.aappublications.org/content/139/5/e20170410

Impact of a Complex Care Management Model on Cost and Utilization Among Adolescents and Young Adults with Special Care and Health Needs https://www.ncbi.nlm.nih.gov/pubmed/28338416
An Unexpected Use of My Internal Medicine/Pediatrics Training

In 2005 when Hurricane Katrina swooped in and left massive devastation in Louisiana and Mississippi, patients were stranded in the hospitals of the Gulf Coast and New Orleans. The destruction of Katrina resulted in nearly 2000 deaths, with an additional 700 people reported missing. Thousands of people were left homeless and large-scale evacuations from areas most affected by the hurricane and subsequent flooding were evacuated to cities throughout the South and Midwest. Hospitalized patients were a particularly difficult population. Especially in New Orleans, hospitals lost needed electrical power and personnel necessary to provide quality patient care. The heroic endeavors of the hospital personnel included providing the best care possible for patients while having very limited resources and no infrastructure to support any patient care endeavors.

The children’s hospital I work for in Kansas City sent transportation to New Orleans to transfer pediatric patients that required hospitalization to our hospital for continued care. As I recall, 10-12 patients were transferred to our hospital. They began arriving in the late afternoon, and our hospital personnel promptly identified a new issue: the children arrived with parents. And those adults also needed care for their own medical conditions. Everything they owned had been lost in the flooding and they arrived without anything, including medicines. The CMO of the hospital contacted me in the early evening hours and requested that I, as a Med/Peds physician, assist the adult parents of the children. He informed me that asking the parents to go to a local clinic, emergency department or urgent care after just arriving in Kansas City seemed inhospitable and had additional logistic challenges. He requested that I use my Med/Peds training in the pediatric hospital to provide care for the adults, and offered a lot of resources to do so.

The parents had arrived without money, without local resources, without insurance cards and some were unaware of the names of their medicines. I began visiting parents in their child’s hospital room and providing medical services. It was a group endeavor – pediatric nurses, pharmacists, social workers and Med/Peds physicians worked together to provide the best care we could to the parents. The details of our endeavors were a challenge – documentation, follow up arrangements, identifying adult subspecialists for patient care (especially behavioral health resources). We all worked together to later address the challenges as we initially focused on providing our best to our adult patients in a pediatric hospital. I recall the pharmacist contacting me many times to confirm a medication dose before finally understanding that I was prescribing for adults. Eventually our partner clinical affiliate assisted us in caring for the adults, providing similar services. But on that first night and the next several days, when we began to do what was right for our patients’ family members despite a crazy amount of potential obstacles, our group felt rewarded and fortunate that we had the training needed to assist.

Brenda Rogers, MD, FAAP, FACP
Associate Professor, Internal Medicine/Pediatrics
University of Missouri-Kansas City School of Medicine
Every year, the Council of Florida Medical School Deans meets with legislators in Tallahassee. This year I joined the Council in Florida’s capital as a resident representative. These are the 5 most important lessons I learned.

1. There are less than 5 doctors in the state legislature. One hundred and sixty legislators form the Florida House and Senate, which make decisions on over 3000 bills during its 60 day session. Yet less than 5 of those legislators are physicians. Decisions pertaining to an optometrist’s right to perform surgery, a nurse practitioner’s scope of practice, a patient’s prior authorizations, and other health care regulations will all be made by non-physicians. While medical advocacy groups such as the American Medical Association (AMA) and the Florida Medical Association (FMA) and others work to inform policy makers, we need more physicians to be on the frontline of making these decisions.

2. It’s about the money. Whether it’s block grants, retrospective payments, or whatever other economic jargon gets thrown at us, legislators routinely end up politicizing real medical issues. We need knowledgeable voices with medical backgrounds fighting to make sure government dollars go where they can do the most good.

3. One person can make a big difference. Take, for instance, Celeste Philip, a family physician and public health and preventative care professional who was at the forefront of fighting Zika during her first year as the state’s surgeon general. She fought hard to secure funding for Zika research and testing. You don’t have to be surgeon general to make a difference, but it demonstrates how it helps to have a knowledgeable voice like hers inside the government. And while a single voice can make a difference, voices are even better. In Florida, pediatricians worked tirelessly to ensure that physicians could continue asking patients if they owned a gun and counseling them on gun safety, without fear of losing their medical license.1,2 We have a responsibility to use our voices to hold those making health-related decisions accountable.

4. Educating the public isn’t easy. Speaking of Zika, an aerial insecticide called naled was used in Miami to curb active transmission of the virus. But there was public outcry that spraying might do more harm than good. Though naled can be dangerous in large quantities, in this case, less than one ounce of naled was used per acre. In Miami, patient visits for asthma, reactive airway disease, wheezing, or shortness of breath did not increase.3 Despite assurances that the benefits of spraying far outweighed the risk, many people still had their doubts. One patient believed that his myocardial infarction and congestive heart failure were directly caused by the pesticide. This is where public voices matter. Public relations matters. Spreading a cohesive message matters. And having more physicians in public posts is a key piece of distributing these messages.

5. We must advocate for our patients, friends, families, and even ourselves. Recently at Jackson Memorial Hospital, we organized a town hall meeting where the hospital’s CEO, local representatives and health providers discussed the Affordable Care Act and the future of health care. Hundreds attended and were engaged in the conversation, passionately sharing their own experiences serving patients in our complicated health system. From marching in the Women’s March in D.C, to calling in and writing to our legislators, to organizing meetings to discuss health care, there are things that we as residents, fellows, attendings, students, and citizens can do. In order to effectively advocate for our patients’ well-being, we must advocate for social and political change. The future of our country is in our hands, and we must ensure that we advocate for what we believe in.

Diana Botros, MD
Internal Medicine—Pediatrics, PGY2
University of Miami / Jackson Memorial Hospital

References:
This past Match Day, my medical school matched students into Med-Peds for the first time in ten years. This represents a fifth of the history of Med-Peds without Washington University in St. Louis (WashU) students going into Med-Peds. I’m happy to say that three of us entered the field this year, and I think it brings up two important messages: vulnerability and visibility.

At WashU, most students opt-in to being called up randomly one at a time to come to the front of the auditorium, open their envelopes, and read out into the microphone where they matched. This practice allows everyone to share in that student’s authentic emotional experience and also makes public an often-perceived private moment. What it did for Med-Peds is make the field more publicized.

Knowing that WashU’s absence of a Med-Peds program makes general knowledge about the field fairly low, I practiced how I would announce my matched program: “I matched in combined Internal Medicine/Pediatrics at…”. I noticed that people often only listen to the last word and think I’m going into Pediatrics, so I thought that adding “combined” might help effectively communicate my residency field. Since matching, I’ve continued to hear, “How many programs are there?”, “Oh really? That many?”, “Is it because you just couldn’t decide between the two?”, and other questions that demonstrate the need for greater publicity and awareness.

We need to utilize the excitement of our 50th anniversary this year to promote greater visibility on a national scale, especially at institutions where there are no programs. Through the medical student subcommittee of NMPRA, we have worked this past year on better assessing the number of Med-Peds Interest Groups and plan to focus on promoting student groups first at institutions with Med-Peds programs, then expanding to those without one.

In 2017, 78 Med-Peds programs offered a total of 381 spots for incoming interns through the Match. There were more potential slots for Med-Peds than for Neurological Surgery (218), Otolaryngology (305), or Plastic Surgery (159). These surgical specialties, however, do not run into the same issues with national visibility. To increase visibility, though, our advocacy may require vulnerability. NMPRA members did some of this work by promoting Med-Peds at UCSF during this past year’s conference in San Francisco. I proudly yet vulnerably shared at our Match Day for the first time in a decade that a WashU student was entering the Med-Peds family. I look forward to all of us further sharing our excitement for this field. Embrace vulnerability and promote visibility through more Med-Peds programs and more Med-Peds Interest Groups nationwide.

Austin Wesevich, MPH
Washington University School of Medicine, Class of 2017
Duke Med-Peds, Class of 2021
NMPRA Medical Student Subcommittee
Acute Fatty Liver of Pregnancy (AFLP), a rare disorder unique to pregnancy, is characterized by a microvesicular fatty infiltration of hepatocytes. Prior to medical advancements and progressive research about the condition, it was initially thought to be universally fatal. AFLP is rare in the sense that it has an approximate incidence of 1/7,000 to 1/20,000 deliveries. The pathogenesis of the AFLP has some association with inherited defects in mitochondrial beta-oxidation of fatty acids, most commonly long chain hydroxyacyl-CoA dehydrogenase (LCHAD) deficiencies in some affected women and fetuses. If fetuses inherit any of these deficiencies their mothers may be predisposed to the hepatotoxicity secondary to toxic substrate circulating in the maternal bloodstream.

A 23 year old G2P1 at 38 weeks gestational age with no past medical history presented to the hospital emergency department with a 5 day history of nausea, protracted vomiting, and poor oral intake. She sought treatment after the onset of a new severe headache. The headache lasted for four hours and was refractory to pain medicine. Her review of systems was otherwise negative. The patient denied any family history of genetic disease, coagulopathies, or kidney disease. She also denied blurred vision, abdominal pain, pruritus, hematuria, or fluid leakage. Physical exam findings were unremarkable. Vitals upon admission revealed tachycardia (137 bpm), hypertension (systolic max=148 mmHg; diastolic max= 114 mmHg), hypoglycemia (47 mg/dL), and tachypnea. She was also found to be profoundly coagulopathic exhibiting features similar to DIC with fibrinogen levels of 61.7 (nl = 373-619), partial thromboplastin time of 49 (nl = 24-35), INR 2.2 (nl = 0.8-0.94), and prothrombin time of 24.2 (nl = 9.6-12.9) seconds. Her liver function tests indicated transaminitis with ALT of 448 (nl = 2-25) and AST of 300 (nl = 4-32), along with ALK-P of 975 (nl = 38-229), LDH levels of 577 (nl = 82-524), and T. Bili levels reaching 10.0 mg/dL (nl = 0.3-1.2). Metabolic acidosis secondary to lactic acid levels of 4.5 mmol/L (nl = 6-16 mg/dL) were also observed. In addition, her labs indicated signs of acute kidney injury with Creatinine levels of 1.8 mg/dL (nl = 0.7-1.3).

After careful analysis of clinical and laboratory findings to rule out preeclampsia and HELLP syndrome, she was given the diagnosis Acute Fatty Liver of Pregnancy. The patient was made aware of her diagnosis and given the opportunity to consider her delivery options. Upon cervical examination, the patient was not dilated and was therefore determined to be remote from delivery. A caesarean section was performed and post-operatively the mother was transferred to the ICU to optimize management of her coagulopathy. Her abnormal laboratory studies normalized by post-operative day four and she was discharged home with her newborn baby. The patient gave informed consent and elected to undergo a Cesarean delivery. Considering the patient’s significant coagulopathic state requiring emergent surgical intervention, she was administered a total of 7 units of fresh frozen plasma and 2 units of cryoprecipitate to achieve hemodynamic stability throughout her operative course. She gave birth to a 2,820 gram female with APGAR score of 7 & 8 at 1 and 5 minutes, without experiencing any surgical complications.

Early diagnosis and prompt delivery have become paramount in reducing unfavorable maternal outcomes in AFLP as well as HELLP and preeclampsia/eclampsia syndromes. These three disorders either closely mimic the clinical course of AFLP, its management, and or its risks. The maternal morbidity and mortality of AFLP patients has considerably declined in recent years due to the success of prompt delivery in producing progressive clinical resolution. It is now of utmost importance to place further attention on early recognition and management of LCHAD and its associated enzyme deficiencies to curb the future of fetal and neonatal mortality.
Med-Peds Attends SGIM National Meeting

The Society of General Internal Medicine (SGIM) held their national meeting in Washington DC in April. The theme of the meeting was "Resilience and Grit: Pursuing Organizational Change and Preventing Burnout in GIM". Consistent with the theme, Med-Peds groups were well represented and reunited to support each other in our pursuits of innovation in clinical practice, education, advocacy and research.

The SGIM Task Force "GIM for Young Adults" formally known as "Adults with Complex Care Originating in Childhood" meets annually at the national meeting. The task force includes many Med Peds leaders with expertise in caring for patients with special health-care needs and has rebranded to expand its focus on caring for the young adult. It is the hope of the Task Force to serve a catapult for adult providers embracing the care for all young adults including those with chronic conditions originating in childhood and other special health care needs.

Also at the national meeting, SGIM welcomed the newly created Med-Peds Interest Group. The MPIG hopes to create an academic home for Med-Peds members at SGIM, working in synergy with existing national organizations as well as SGIM's GIM for Young Adults Task Force and Adults with Complex Conditions Originating in Childhood interest group. The "launch meeting" attracted nearly 30 enthusiastic and active SGIM members with a background in Med-Peds (see photo). Moving forward, the MPIG hopes to support a mentor/mentee network (with an initial focus on connecting medical students and residents), compile a list of Med-Peds members in SGIM including their clinical, programmatic and scholarly activities and interests to promote collaboration, and highlight the "value" of Med-Peds trainees, physicians, educators and researchers to SGIM.

As SGIM and Med-Peds begin to celebrate anniversaries this year, we look forward to continued partnerships and shared academic homes.

If you are interested in joining SGIM, please see http://www.sgim.org/membership/join-sgim/trainee-benefits. There is also a link for SGIM members to join interest groups: http://www.sgim.org/communities/interest-groups
While 2017 continues to be a year long celebration of our collective achievements and a springboard for continued excellence, we are really excited about the big celebration Saturday, September 16th in Chicago. We don't want to give away all the surprises we have planned but we will be having a great dinner, an open bar, and some excellent entertainment. We hope you will join us in this celebration that won’t be forgotten and stay tuned for more information in the coming months. Thank you for all you continue to do to make Med-Peds a career worth celebrating!

See you in September!

Midwest Regional Meeting held on April 8, 2017
Hosted by: Ohio State University & Nationwide Children’s Hospital, Columbus, OH
Theme: A Tale of Two Departments– The nuts and bolts of finding your ideal combined Med-Peds job

West Regional Meeting held on April 9th, 2017
Hosted by: Loma Linda University Health
Theme: Celebrating 50 years of Dual Training And A Look Towards The Future

MPPDA 2017 50th Anniversary
A big shout-out to all the Med-Peds programs that participated in the 2nd Annual NMPRA Community Service Day, which was held on Saturday, March 4, 2017! Medical students, residents, and faculty members engaged in a variety of service activities to positively influence the lives of people living in our local communities. Please see the amazing photographs below. **Kalamazoo Med-Peds** is the winner of this year’s competition for being the most eco-friendly program: recycling t-shirts to make bags for the homeless...what a great idea! If your program took part in this activity but is not featured below, please send your photos to Nupur Agrawal at outreach@medpeds.org. We are hoping to upload the photos to the NMPRA website and would love to brag about you!

**Winners!** **Kalamazoo Med-Peds** made t-shirts into bags for the homeless. Over 100 t-shirts were made by faculty and residents in Med-Peds, Pediatrics, and Internal Medicine.

**Baylor Med-Peds** residents and medical students got their farm on by volunteering with Plant It Forward, which is a community organization that helps refugees grow their own urban farm businesses!
Baystate Med-Peds prepared and served dinner at the Springfield Rescue Mission on March 11th. A great time and delicious enchiladas were had by all who participated!

University of Miami/Jackson Med-Peds served up hot lunch at a local shelter!