In a recent newsletter, I described the “History of Pediatric Nephrology Project” that I have been fortunate to be involved in. A discussion among our Executive Committee about that project prompted those on our executive committee to seek information about efforts to capture history within the AAP. I was gratified to learn that the AAP has a project designed specifically to encapsulate and highlight its history, called the Pediatric History Center (PHC). As stated on the AAP website, the PHC “houses all historic and official Academy records. Publications, policy statements, selected documents, photographs, and books on AAP history are preserved as a lasting record and resource that documents the Academy’s role in “advancing child health”. Herein, we appreciate the opportunity and privilege to feature the components of the PHC.

The PHC captures major historical landmarks of pediatrics and of the AAP. This effort was initiated in 1952 by the AAP historian Dr. Marshall C. Pease. At that time, Dr. Pease summarized the history of the AAP from 1930 to 1951. This was followed by further efforts by historians and AAP presidents. Most notable was the work of Dr. Howard A. Pearson, who became president of the AAP in 1992 and spearheaded the establishment of the PHC. The major goal of the PHC and the Historical Archives Advisory Committee (HAAC) is “in promoting an interest in the history of the profession of pediatrics and child health”.

The PHC and HAAC contain several components and collections, including the Historical Medical Collection which collects information about the history and timelines of the American Medical Association, vaccines, and maternal and child health. There are links to medical collections, the U.S. Library of Medicine, and features of renowned leaders in public health and medical research. Finally, there is a link to the Clifford G. Grulee collection of European and American pediatric textbooks in the world, dating back to the 15th Century.

The History of Pediatrics Sources contains histories of various topics of interest to pediatricians, including children’s health, pediatric subspecialties, child health organizations, and biographies of influential pediatricians.

The PHC also contains valuable teaching resources such as
a history of how teaching was developed and conducted during morning rounds along with PowerPoint presentations exhibiting early pediatric history and suggestions for educating students. This project takes the evaluation of teaching into the modern age with discussions about how to use the internet and social media during teaching sessions. Additionally, one can find treasured links to historical articles about the AAP, pediatrics, and pioneers in the field of pediatrics. Links to external resources such as the U.S. National Library of Medicine provide interesting information about the world’s largest history of medicine collections through the History of the Health Sciences Section of the Medical Library Association, PubMed, and rare medical texts. Finally, material about articles that portray current pediatric practice is also provided.

The PHC also includes information about various collections of unique artifacts and histories of the AAP sections and committees, dating back to the 1940s.

Perhaps the most fascinating and unique part of the PHC is the Oral History Project. As stated on the website “the American Academy of Pediatrics Pediatric History Center is working to preserve and document the rich heritage of the profession of pediatrics...the center is engaged in collecting documents and memorabilia related to the history and development of the profession of pediatric and child health care, maintaining the AAP archives, and producing oral histories of leaders in the advancement of children's health care”. Material is generated through comprehensive interviews with influential pediatricians and other leaders. There are recordings and written transcripts of the interviews. Leaders interviewed thus far for this project include Drs. T. Berry Brazelton, Audrey K. Brown, MD, C. Everett Koop, Abraham M. Rudolph, Samuel Katz, and Louis Gluck.

Of particular interest to pediatric nephrologists are the interviews with Drs. Henry Barnett (of the famed Henry L. Barnett Award to recognize the contributions of Dr. Barnett to the field of pediatric nephrology), Clark D. West, and Thomas Starzl.

While all of the interviews offer fascinating insight, the Barnett recording is a prime example of the value of these interviews. The interview was conducted over several months in 1996. Dr. Barnett, who was born in 1914, describes his family history and his childhood in Tulsa, Oklahoma, including winning the national interscholastic record in breaststroke in high school, an activity he enjoyed throughout his life. He describes his mother as the most influential person in his life, highlighting her role in protecting a black family during local riots. He recalls his internship as a time when “you were on every other night and you were up most of the night...there was not much social life outside of the hospital, although there was a place where we used to drink beer occasionally.” A pediatrician named Dr. Alexis Hartmann was a major influence on his pursuit of developmental physiology and fluid and electrolyte therapy in children. Dr. Barnett recollects a fascinating experience working in New Mexico in the early 1940s, near where the first atom bomb was being developed. He was part of a group of physicians who “went to Nagasaki, Japan to monitor the cities where the bombs had been dropped to see if it was safe for occupation troops”.

Dr. Milton J. Senn influenced Dr. Barnett to go to work at Cornell. There, he originally considered a career in behavioral psychology, but based on his success in research of developmental physiology, he pursued the latter. Dr. Barnett discusses many important personal and professional issues he encountered such as the relationship between pediatrics and internal medicine, anti-Semitism, the development of international consortiums, his emphasis on developing teachers and professors, his major role in the establishment of the department of pediatrics at the Albert Einstein College of Medicine and in developing the most renowned pediatric nephrology department with the strong support and leadership of Drs. Chester Edelman and Adrian Spitzer. Dr. Barnett was very interested in the relationship between primary care pediatricians and sub-specialists. While he believes that primary care doctors can learn about and screen for serious diseases, “the specialists, I don't think, can do primary care and I don't think the person in primary care can do very much of specialized care.” He conveys that residency training is too focused on tertiary care, potentially contributing to the difficulties facing primary care doctors who are burdened with numerous tasks their training may not have prepared them for. He proudly discusses his role in the Children's Aid Society, a project that focuses on foster care, adoption services, and developing community centers.

The final segment of the interview focuses on Dr. Barnett’s perception of the roles of clinicians in research. He eloquently states: “I don't think the basic scientist can really know how things they're discovering apply to clinical medicine and I don't think the clinical investigator who is in a position to know how their findings can be applied to clinical medicine can himself do all the basic science that's required. I believe that more and more cooperation is going to be necessary, and I think it's being done in many places.”

Continued on Page 3
In many ways, Dr. Barnett and many others served as pioneers during an exciting but simpler time. They have so much to contribute to our understanding of history while also providing immensely essential foresight into the future of medicine. As is true for the entire AAP Pediatric History Center, we learn that a look into the past is simultaneously a guide to our future.

**PediaLink and Quality Improvement**

PediaLink QI empowers pediatricians and pediatric subspecialists to implement QI methods, foster collaboration among multidisciplinary teams that form a community of QI learners, and allow change to be implemented and measured that is relevant to specific needs of a patient population.

PediaLink QI is a personalized quality improvement program developed to help the board certified pediatrician enhance performance and optimize outcomes relevant to his or her practice of medicine. PediaLink QI was designed to be beneficial to all pediatricians regardless of specialty, location, practice type, population served, or time spent in clinical care. It is grounded upon adult learning principles, behavioral change theory and stages of physician learning and is built upon the model of practice-based continuous professional development (CPD). PediaLink QI allows participants to apply quality improvement principles at the “point-of-care” most meaningful to one’s individual sphere of practice leading to deeper learning, an increased level of engagement and greater motivation for change. [Learn More](#)

**Fellow Corner:**

**Utilizing Social Media to Enhance Nephrology Education**

*Brian Stotter, MD, FAAP*

*SONp Training Fellow Liaison*

*Boston Children's Hospital*

*Division of Nephrology*

As the new Fellow Liaison for the Section on Nephrology (SONp), I’d like to thank all our new and current members, particularly medical students, residents, and fellows, for joining the SONp and giving value to our work. I encourage you all to engage in one or more activities within SONp, or elsewhere outside your training program, to enrich your nephrology educational experience. We have ongoing projects to educate medical students and residents (SONp Teaching-On-The-Go) and the lay public (Nephrology Social Media Toolkit) on pediatric kidney disease, and if you’re interested in either of these initiatives feel free to contact me.

One way to enhance nephrology education and build community with other healthcare professionals is by using social media. This refers to the use of online platforms (Facebook, Twitter, Instagram, etc.) to share resources, exchange ideas, and publicize content to a wide audience. For this article I will focus primarily on Twitter, which has become popular among medical professionals because of the ability to facilitate real-time discussions with peers joining from various geographic locations. Users can “tweet,” or post content from talks at national meetings (with permission) or express their own viewpoints on these topics to share with other attendees, as well as those who aren't present. Twitter use was in full force at ASN Kidney Week this past November, where thousands of tweets communicated the latest nephrology research. Have a question for a speaker, or want to know the reference for a certain teaching point? Ask the virtual audience on Twitter, or even send the speaker a tweet, and you might get your answer.

**What are some ways to use Twitter for your education and professional development?**

1. **Follow national organizations:** There are many professional organizations that engage members and promote advocacy by disseminating information on their Twitter profiles. For starters, in general pediatrics look for the AAP (@AmerAcadPeds), the AAP Section on Pediatric Trainees (@AAPSOPT), and the Pediatric Academic Societies [Learn More](#).
Fellow Corner . . . Continued from Page 3

Many nephrology-focused organizations have active Twitter profiles as well, including the American Society of Nephrology (@ASNKidney), American Society for Pediatric Nephrology (@ASPNeph), and International Pediatric Nephrology Association (@IPNA_PedNeph), to name a few.

2. Use hashtags to follow key conferences: Use #AAPNCE at the AAP National Conference & Exhibition, or #KidneyWk when tweeting at ASN KidneyWeek, to see what other attendees are learning at the conference and catch up on multiple sessions at once.

3. Learn urine microscopy and renal pathology: Many nephrologists and pathologists use Twitter to post images of urine sediments and renal biopsies for teaching purposes. Follow the hashtags #urinarysediment and #renalpath to find an endless supply of images to learn from yourself, or use them to teach medical students and residents when you aren't near a microscope.

4. Stay connected to the latest research: Several medical journals have Twitter profiles, and by following them you can have their posts delivered right to your Twitter feed. Look for content from various AAP publications (@AAPJournals), New England Journal of Medicine (@NEJM), Pediatric Nephrology (@Ped_Neph), and many more.

5. Participate in an online journal club: NephJC (http://www.nephjc.com) is an online nephrology journal club that utilizes Twitter to discuss key research, guidelines, and other publications within the field. Articles are discussed at specific times twice a month in real time, with a host using the NephJC Twitter handle (@NephJC) to ask questions of participants using the #NephJC hashtag in their tweets. Missed a journal club? You can find the archived conversation from each week on the NephJC website.

Ready to get involved? Start a Twitter profile and follow your favorite professional organizations and journals. Look for your colleagues, and see who they follow. I hope to see you online soon, and feel free to message me (@StotterMD) to learn more about optimizing your Twitter experience.

Further Reading:

Section Expertise & Volunteering Survey

The SONp Executive Committee would like to know the interests and expertise of our members. To that end, we invite you to respond to a short 2-question survey at: https://www.surveymonkey.com/r/5GBDJJS The SONp Executive Committee is relatively small group. Among other activities, each year the SONp Executive Committee is asked to review and comment upon many AAP Statements, textbook materials and other items produced in conjunction with various AAP Committees, Councils and Sections, as well as writing an annual article for AAP News. This survey will give SONp members an opportunity to identify those areas of pediatric nephrology where they may wish to volunteer their expertise such as reviewing certain textbook chapters, writing something for the SONp newsletter or AAP News, etc. For those members who want a more active role in the SONp, this survey will provide us the means to better identify your interests and to contact you, individually, as opportunities arise.
Pediatric Hypertension – What’s New in the New Guidelines

Tammy Brady, MD, PhD, MHS FAAP
Associate Professor of Pediatrics
Medical Director, Pediatric Hypertension Program
Johns Hopkins University School of Medicine

Pediatric hypertension is not a new problem for practicing pediatricians, however the number of children with both elevated blood pressure (BP) and hypertension has increased dramatically over the last several decades. Along with this increase, our understanding of the pathogenesis, progression and prognosis of pediatric hypertension has also grown substantially. Even more striking than the knowledge gained over the last several decades, however, is how much this added knowledge has highlighted what is still yet unknown. With this rapid growth in the field of cardiovascular disease (CVD) prevention, diagnosis and treatment there has been an evolution in how children at increased CVD risk are managed. In August 2017 the American Academy of Pediatrics published new clinical practice guidelines regarding BP measurement and hypertension diagnosis and treatment in children. These comprehensive guidelines were developed after an exhaustive review of >15,000 published manuscripts. The evidence was then developed into 30 evidence-based Key Action Statements and 28 consensus-based Recommendations for topics lacking sufficient evidence. Some of these management recommendations are unchanged from the last pediatric hypertension guidelines, published in 2004 and widely referred to as the “Fourth Report”. There are several notable differences, some of which will be briefly summarized and highlighted here.

Most noteworthy about the new guidelines is the emphasis on simplifying hypertension diagnosis and treatment. Instead of recommending BP measurement at each health care encounter for all children it now recommends BP measurement yearly at preventive visits for all children, with BP measurement at each health care encounter reserved for those with increased CVD risk. Those at risk include children with overweight/obesity, chronic kidney disease, diabetes mellitus, history of aortic coarctation repair, and those taking medications known to increase BP.

It goes without saying that essential to the diagnosis of hypertension is accurate BP measurement and recognition of BP elevations. We and others have shown that, even with electronic health record alerts, providers continue to under-recognize BP elevations3. It is postulated that this under-recognition is related to the multiple steps required of pediatric providers to determine normal BP thresholds for each child, as these have all been age-, sex- and height-based. Further complicating matters, the tables in the Fourth Report provided BP percentiles that didn't easily correlate with Hypertension Stage (Stage II HTN = 99th %ile PLUS 5 mmHg; the tables provide the 99th percentile BP; requiring providers to take an additional step in adding 5 mmHg to this value). In response to this, the new guidelines have not only updated the normative tables to provide the stage II hypertension cutoff (now labeled as the 95th %ile + 12 mmHg) but it has changed the definition of HTN for adolescents. While children under 13 years of age continue to have percentile based definitions of hypertension, those 13 years of age and above now have uniform BP values to define each stage of BP (normotension, elevated BP, stage I HTN and stage II HTN; “Table 3” see page 6).

To further assist with recognition of elevated BPs, an additional table is provided in the guidelines to provide values for each age that should “trigger” a repeat measurement. This tool could easily be used in a triage setting so that repeat measurements can be obtained prior to the patient being seen by their provider (“Table 6”).

Another significant change is that the normative BP tables were completely updated to provide the BP norms of children of normal


TABLE 6 Screening BP Values Requiring Further Evaluation

<table>
<thead>
<tr>
<th>Age, y</th>
<th>BP, mmHg</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Systolic</td>
<td>DBP</td>
<td>Systolic</td>
</tr>
<tr>
<td>1</td>
<td>96</td>
<td>52</td>
<td>98</td>
</tr>
<tr>
<td>2</td>
<td>100</td>
<td>55</td>
<td>101</td>
</tr>
<tr>
<td>3</td>
<td>101</td>
<td>58</td>
<td>102</td>
</tr>
<tr>
<td>4</td>
<td>102</td>
<td>60</td>
<td>103</td>
</tr>
<tr>
<td>5</td>
<td>103</td>
<td>63</td>
<td>104</td>
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<tr>
<td>6</td>
<td>105</td>
<td>66</td>
<td>105</td>
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<tr>
<td>7</td>
<td>106</td>
<td>68</td>
<td>106</td>
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<td>8</td>
<td>107</td>
<td>69</td>
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<td>9</td>
<td>107</td>
<td>70</td>
<td>108</td>
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<tr>
<td>10</td>
<td>108</td>
<td>72</td>
<td>109</td>
</tr>
<tr>
<td>11</td>
<td>110</td>
<td>74</td>
<td>111</td>
</tr>
<tr>
<td>12</td>
<td>113</td>
<td>75</td>
<td>114</td>
</tr>
<tr>
<td>≥13</td>
<td>120</td>
<td>80</td>
<td>120</td>
</tr>
</tbody>
</table>

Continued on Page 6
weight. The previous tables published in the 2004 Fourth Report included data from over 60,000 healthy children who were participants in one of 11 different research studies. Twenty-one percent of the children included in this database had a BMI ≥ 85th percentile. Removing the BP's contributed by these children resulted in systolic and diastolic norms being several mmHg lower.

Example:

<table>
<thead>
<tr>
<th>Height Percentile – 12-year-old Boy</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>90th %ile SBP</td>
</tr>
<tr>
<td>All Children (2004 Fourth Report)</td>
</tr>
<tr>
<td>Normal Weight Norms (2017 Clinical Practice Guidelines)</td>
</tr>
<tr>
<td>90th %ile DBP</td>
</tr>
<tr>
<td>All Children (2004 Fourth Report)</td>
</tr>
<tr>
<td>Normal Weight Norms (2017 Clinical Practice Guidelines)</td>
</tr>
</tbody>
</table>

The BP tables provided in the new clinical practice guidelines now only includes this BP data from the almost 50,000 children with healthy weight who were included in the Fourth Report.

With the epidemic of obesity in the US and worldwide and its known association with hypertension, target-organ damage and co-morbid CVD risk factors, the evaluation of children with confirmed hypertension has been streamlined. These updates will allow for better risk stratification and identification of comorbid conditions known to elevate CVD risk across the lifespan.

While primary HTN remains a diagnosis of exclusion, the new guidelines recommend a less extensive initial evaluation for most children. Specifically, children six years of age and older do not require an extensive evaluation at initial diagnosis if they have a family history of HTN, overweight or obesity, and/or an absence of findings suggestive of a secondary cause of HTN. Two notable studies that are no longer uniformly recommended for all children with hypertension at initial diagnosis are renal ultrasonography and echocardiography. These studies have their role in the evaluation for selected children with hypertension. Renal ultrasound should be pursued in children under 6 years of age and in children with concern for kidney disease (which may be suggested by an elevated creatinine or abnormal urinalysis). Echocardiography is now reserved for children who will be initiated on an antihypertensive medication and then every 6-12 months after antihypertensive medication initiation to monitor for the development or regression of target organ damage (left ventricular hypertrophy, diminished ejection fraction). Further, the definition of left ventricular hypertrophy is now simplified to left ventricular mass index $>51$ g/m$^2.7$ for all children 8 years of age and above instead of by an age- and sex-based percentile definition.

While ultrasound and echocardiography are noticeably absent in the recommended initial evaluation for all kids, a prominent addition is the expanded role for 24-hour ambulatory BP monitoring (ABPM). The new clinical practice guidelines recommend 24-hour ABPM for all children with prehypertension for a year or longer, at initial diagnosis of HTN, for children with high risk conditions (including heart and/or kidney transplantation, coarctation of the aorta repair), in addition to the more traditional indications for 24-hour ABPM: to diagnose white coat hypertension, to assess treatment effectiveness particularly when home/clinic BPs suggest insufficient response to treatment, and to evaluate BP in children with known/suspected obstructive sleep apnea.

Regarding updates on treatment, there were several important changes in the new guidelines. Regardless of CVD risk, BP should be treated to a goal of <90th percentile or < 130/80 whichever is lower. Additionally, there are now specific recommendations regarding degree of sodium reduction that should be recommended (<2300 mg/day) and initial choice of antihypertensive medications (angiotensin converting enzyme inhibitors, angiotensin receptor blockers, long-acting calcium channel blockers, thiazide diuretics).

In addition to the evidence-based guidelines and expert consensus-based recommendations detailed in the clinical practice guideline, the guidelines also highlight many areas in which further research is needed. The role of home BP monitoring, school based BP measurements, and other cardiovascular assessments such as arterial stiffness and carotid intima media thickness measurements is still not clear at this time. Further, there are other areas addressed in the CPG to assist providers caring for children with increased CVD risk, succinctly summarized in tabular format and described in greater detail in the text. This summary was meant to highlight some of these updates but not serve as a comprehensive review. Please refer to the Clinical Practice Guidelines for other updates and resources that are available to assist with the ongoing challenge of cardiovascular disease prevention and treatment.

References:


Continued on Page 8
 AAP Move to New Headquarters

The AAP moved to its new headquarters in Itasca, Illinois in early December. Our new address and phone numbers are below:

• New Mailing Address: American Academy of Pediatrics, 345 Park Blvd., Itasca, IL 60143
• New AAP Main Number: 630-626-6000
• AAP Toll Free: 800-433-9016
• AAP Customer Service: 866-843-2271
• AAP Main Fax: 847-434-8000

Nomination Call for AAP Committee Members

The call for nominations for 2018 national committee member positions is now open until February 23, 2018. Member appointments will take place at the May 2018 Board Meeting and new Member terms will begin on July 1, 2018. For more information about the current open positions and process for submitting a nomination, please visit the AAP Committee Nominations webpage (AAP login and password required). Below is a list of Committees with open positions:

• Committee on Adolescence (COA): 1 position
• Committee on Coding and Nomenclature (COCN): 1 position
• Committee on Continuing Medical Education (COCME): 1 position
• Committee on Development (CODE): 3 positions
• Committee on Fetus and Newborn (COFN): 1 position
• Committee on Infectious Diseases (COID): 1 position
• Committee on Nutrition (CON): 2 positions
• Committee on Pediatric AIDS (COPA): 1 position
• Committee on Pediatric Education (COPE): 2 positions
• Committee on Pediatric Emergency Medicine (COPEM): 1 position
• Committee on Pediatric Workforce (COPW): 2 positions
• Committee on Practice & Ambulatory Medicine (COPAM): 2 positions
• Committee on Psychosocial Aspects of Child and Family Health (COPACFH): 2 positions
• Committee on State Government Affairs (COSGA): 2 positions

Compendium Helps Pediatricians Implement Telehealth Visits into Practices

The AAP has developed a telehealth compendium, an online resource that offers general information and technical support for pediatricians who want to incorporate telehealth services into their practices. Learn how to get started offering patient visits, identifying coding, and quality improvement and evaluation. This resource also includes template documents and most recently added a searchable directory of telehealth programs. For more information on telehealth, join the AAP Section on Telehealth.
Free Bioethics Teaching Guides Updated and Available Now

The AAP Section on Bioethics and Committee on Bioethics announce the release of the second edition of "Bioethics Case-Based Teaching Guides for Resident Training." This case-based modular curriculum offers 20 different sessions to assist pediatric faculty and trainees develop foundational competencies in bioethics. It is free and members are encouraged to share.

CoPS Updates

Dr. Amy Wilson serves as the AAP Section on Nephrology Liaison to the Council on Pediatric Subspecialties (CoPS). You can view the January, 2018 CoPS update and additional information about CoPS on their website.

Call for Nominations:
AAP’s Member Representative to the Pediatric Academy Societies’ (PAS) Annual Meeting

The American Academy of Pediatrics is looking for a physician member to serve as its official representative to the PAS Annual Meeting. Currently, four partner societies comprise the governing bodies of the PAS Annual Meeting. These include the American Pediatric Society (APS), Society for Pediatric Research (SPR), American Pediatric Association (APA) and the American Academy of Pediatrics (AAP).

Term of Office
It is requested that the representative serve for five years; starting in Spring, 2018.

Duties
Responsibilities include:
• To serve as a voting member of the PAS Operating Committee, Program Committee and Executive Committee.
• To participate in all meetings, teleconferences and subcommittees related to each committee.
• To provide direction and leadership for AAP’s five Program Committee members; to coordinate terms of office and selection as such.
• To work with others to select abstracts and workshops as assigned.
• To report to the AAP Board regarding PAS activities and decisions.
• To serve as the chair of the Operating Committee from May 2020 to May 2022.
• To serve all four of the partner societies in the best interest of the PAS Annual Meeting.

Travel/Time
• Requires travel to 3-5 live committee meetings per year, including the PAS Annual Meeting.
• Preparation for and participation in numerous monthly phones calls for each committee.

Qualifications
AAP wishes to appoint a physician member who is well connected to academic pediatrics and pediatric research and well-versed in the PAS Annual Meeting.

Description of Committees
Below are descriptions of the committee structure for PAS as it currently stands:

Operating Committee: The Operating Committee has full responsibility and decision-making authority for the PAS meeting, excluding responsibilities of the Program Committee. This committee has the authority to make all business and management decisions for the PAS meeting, with assistance from staff. The Operating Committee approves the budget. All Operating Committee members are representatives of the Program Committee. The Operating Committee meets

Continued on Page 10
Program Committee: The Program Committee is a large active group that is responsible for the overall organization, construction and evaluation of the PAS Meeting. The committee is comprised of representatives from the four partner societies (APS, SPR, APA, AAP) and includes representatives from each of the alliance organizations that meet in conjunction with the PAS. In general, the composition of the Program Committee reflects the broad-based interests of the members, guests and trainees who attend the meeting.

Executive Committee: The Executive Committee convenes at the request of the Operating Committee and functions as an advisory board for the PAS. Operating Committee members are also members of the Executive Committee and the President or designee from each partner society.

Deadline for Candidates: Candidates must submit a curriculum vitae and cover letter that includes related qualifications and interest by February 15, 2018 to Lynn Olson, Vice President, Research at lolson@aap.org.

Welcome to our New SONp Members

If you know of others who might be interested in joining the Academy and the Section, please have them call Customer Services at: 866-843-2271 or go to the AAP website. Current Academy members may join the Section by accessing the online application (member ID and login required).

Upcoming Meetings

National Kidney Foundation - 2018 Clinical Meeting
April 10-14, 2018
Austin, TX

2018 Pediatric Academy Societies Congress
May 4 - 8, 2018
Toronto, Canada

European Renal Association-European Dialysis and Transplant Association – 55th Congress
May 24- 27, 2018
Copenhagen, Denmark

51st Annual Scientific Meeting of the European Society of Pediatric Nephrology
October 3 – 6, 2018
Antalya, Turkey

Kidney Week 2017
October 23 – 28, 2018
San Diego, California

AAP National Conference & Exhibition
November 2 – 6, 2018
Orlando, Florida

ISN World Congress of Nephrology 2019
April 12-15, 2019
Melbourne, Australia
For Upcoming Newsletters . . .
We welcome your input and encourage you to submit ideas or information by email to Doug Silverstein, MD at dsilverstein2001@yahoo.com or Suzanne Kirkwood at skirkwood@aap.org for future issues of the newsletter.

The Section on Nephrology Executive Committee

Chairperson:
Douglas Silverstein, MD, FAAP

Executive Committee:
Donald Batisky, MD, FAAP
Vikas Dharnidharka, MD, FAAP
Stephanie Jernigan, MD, FAAP
Teri Jo Mauch, MD, PhD, FAAP
Brian Stotter, MD, FAAP
Amy Wilson, MD, FAAP

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Larry Greenbaum, MD, PhD, FAAP

Nominations Subcommittee:
Deborah Jones, MD, FAAP (Chair)
Steven Alexander, MD, FAAP
David Kershaw, MD, FAAP

Barnett Award Subcommittee
Daniel Feig, MD, FAAP (Chair)
Frank Boineau, MD, FAAP
Mohammed Malekzadeh, MD, FAAP

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Manager, Section on Nephrology

Mark A. Krajeccki
Journal Production Specialist