Dear PCCM Colleagues:

Four years as the Chair of the Section on Critical Care has gone by in a flash, and this will therefore be my last Chair’s report for the Section. Dr Ed Conway will assume leadership for our Section following this fall’s Section program at the AAP National Conference & Exhibition (NCE) in New Orleans. Also, Dr Carley Riley has joined the Section Executive Committee as the Post Residency Training (Fellow) representative. Two other additions to the Section Executive Committee membership, Drs Mary Lieh-Lai and John Straumanis, could best be described as transitions, as both had been active in Section activities for many years. Dr Lieh-Lai joined the group after serving as the editor of this newsletter for many years, while Dr Straumanis has been the Program Chair for the Section’s scientific program at the NCE for a similarly lengthy period. The vacancies in their previous positions have been filled by Dr Luke Zabrocki, who has become Newsletter Editor, and Dr Brad Poss, who has assumed the role of Program Chair.

As noted in the previous Chair’s Report, the SOCC scientific program at the NCE in Boston last fall was excellent, with the first half-day consisting of presentations of original research in both oral and poster formats, followed by educational presentations over the next two half-days. The next SOCC scientific program, at the NCE in New Orleans in October, promises to be superb as well. Research submissions for the meeting were increased in both quality and quantity, and should make for an interesting first morning of the program. In the afternoon, we have scheduled three presentations on management of respiratory failure, including discussions of non-invasive ventilation by Dr Gerhard Wolf, airway pressure release ventilation by Dr Ellie Hirshberg, and support of respiratory failure with limited resources by Dr Niranjan “Tex” Kissoon. Of note, Dr Kissoon will also receive the SOCC Distinguished Career Award later in the program.

On the following morning, topics include traumatic brain injury by Dr Courtney Robertson, multiple trauma by Dr Adam Silverman, and pediatric war injuries by Dr Jon Woods, who is a Captain in the US Navy with extensive experience in the conflicts in the Middle East. Another activity of the SOCC at the NCE will be participation in a “Speed Dating” Session, wherein medical students and residents can have brief conversations with representatives from the various pediatric subspecialties as they consider which field they might want to pursue.

We in the SOCC continue to seek ways to improve the level of participation and engagement in the SOCC by pediatric intensivists. With that goal, two programs have been created in the last year, both aimed at encouraging the presentation of research at the Section program at the NCE and both described on the SOCC website. The first of these is the introduction of travel grants, funded by the SOCC, sufficient to fund travel and lodging, to be awarded to the three best abstracts submitted to the SOCC program. We believe that the offering of these grants were at least partially responsible for the increased number and quality of abstracts submitted for the upcoming SOCC program. The second is the re-introduction of small research grants, also funded by the SOCC. This grant program, overseen by Dr Rich Mink, has yielded 15 grant applications, several of sufficiently high quality such that we have decided to award two grants although the original plan was for one.

(Continued on page 2)
In addition, we have continued ongoing recruitment strategies including mailing of promotional flyers and reduction in initial dues for intensivists who are non-members or lapsed members of the AAP. These efforts have yielded some fruit as the current membership of the SOCC of 689 represents an increase of almost 20% over last years total of 571, although membership has not completely recovered to the peak levels of a few years ago. We plan to continue to encourage SOCC membership, particularly wanting to target AAP members who are eligible for SOCC membership but have yet to join.

Each March the AAP conducts its Annual Leadership Forum (ALF) in the Chicago area, and this year there were several items of business relevant to critical care. Of the resolutions voted “top ten” at this year’s ALF, there were two with implications for critical care, the first regarding AAP collaborations to address drug shortages, and the second addressing the safe use of anesthesia and sedative drugs in children. Also, representatives from the American Board of Pediatrics (ABP) presented information on fellowship training, including whether the length of training should be different between subspecialties, whether research versus pure clinician tracks should be created in fellowships, how competency and achievement might be best measured, and what the purpose of subspecialty certification should actually be. The ABP plans to continue these studies at least through spring 2013 before providing any conclusions.

Another AAP initiative of considerable interest is the upcoming Workforce Survey. This effort, organized by the Division of Workforce and Medical Education Policy, is aimed at gathering specific information about pediatric subspecialists. There are customized versions of the Survey for each subspecialty, and we on the SOCC Executive Committee have had input into the items specific for pediatric critical care medicine. Please be sure to complete the survey once it is finalized and published. The work that has gone into this survey also helps bring home an important point - although the AAP may appear sometimes to be an organization primarily concerned with the general pediatrician, my experiences at the ALF over the past 4 years have assured me that the AAP is equally as concerned with and dedicated to the pediatric subspecialist.

Although many of you may not be aware of it, the SOCC in fact possesses a strategic plan, a document detailing those things that we think are important to our organization, the things that we would like to accomplish, and how we think we might go about doing so. The SOCC Executive Committee has revised the strategic plan over the past couple of years to better reflect our current goals and plans over the next five years. Please take a minute to peruse the strategic plan on the SOCC website. (http://www.testaap.org/moc/memberships/section/CriticalCare/StrategicPlan-2012-2015.pdf)

In conclusion, I must again ask all SOCC members to consider the benefits of involvement in the AAP and the SOCC. The SOCC offers excellent educational programs, as well as the considerable political and advocacy expertise and clout of the AAP. The educational sessions are invariably of good quality, and the SOCC Section program is the best place imaginable for junior investigators to get their feet wet in research presentations.

Please consider presenting your projects here, and encourage your fellow junior faculty, fellows, residents, and even nurses, to do so as well. Look at the SOCC webpage for an overview of the SOCC, members of the SOCC Executive Committee, and an overview of the various activities and resources of the Section. (www2.aap.org/sections/criticare)

Wishing you all the best, and hoping to see a lot of you in New Orleans!
8:00 – 8:15 am  | Scientific Abstract Program - Introduction: Brad Poss, MD, MMM, FAAP

8:15 – 9:30 am  | Oral Abstract Session I
   Moderators: Mary Lieh-Lai, MD, FAAP & Donald Vernon, MD, FAAP

8:15 am  | Christopher L. Carroll, MD, MS
   Location of Intubation & Duration of Ventilation in Children with Acute Asthma

8:30 am  | Joana Anjeh Tala, MD
   Hyperglycemia Increases the Risk of Deep Venous Thrombosis in Non-Diabetic Critically Ill Children

8:45 am  | Katherine Slain, DO
   Predicting Mortality in Pediatric Respiratory Failure: Feasibility of the Oxygenation Index Area Under the Curve

9:00 am  | Jonathan W. Byrnes, MD
   Effect of Antithrombin Supplementation in Pediatric Cardiac ECMO

9:15 am  | Antonio G. Cabrera, MD
   Effect of Dexmedetomidine in Children with Trisomy 21 Undergoing Congenital Heart Surgery

9:30 – 10:30 am  | Poster Walk Rounds & Coffee Break

**Group I**  | Moderators: Alice Ackerman, MD, MBA, FAAP & John Straumanis, MD, FAAP

Veerajalandhar Allareddy, MD, MBA
Epidemiology of Hospital Based Emergency Department Visits Due to Central Venous Catheter Related Blood Stream Infection among Children in the U.S.

Alicia DeMarco, MD
Pediatric Mortality Risk Scores & Initiation of End-of-Life Discussions in a Tertiary PICU

Kristen Nelson-McMillan, MD
Vitamin D Deficiency in a PICU

Kristen Nelson-McMillan, MD
Isoflurane Use in Children with Severe Status Asthmaticus

Venessa L. Pinto, MD
Clostridium Difficile Associated Disease among Children in a PICU

**Group 2**  | Moderators: Carley Riley, MD, MPP, FAAP & Edward Conway Jr, MD, MS, FAAP

Pooja A. Nawathe, MD
Severe Hemorrhagic Coagulopathy with Hemophagocytic Lymphohistiocytosis Secondary to Epstein-Barr Virus Associated T-Cell Lymphoproliferative Disorder

Jeffrey E. Vergales, MD
Face-to-Face Handoff: Improving Transfer to the PICU after Cardiac Surgery

James L. Laham, DO
Clinical Parameters to Predict Extubation Outcome in the PICU

Geetha Challapudi, MD
Outcomes of Tracheostomies in Children with Congenital Heart Disease

Brittany K. Potts, MD
The Myth of Preventable PICU Readmissions: A Review Using a Local Clinical Database

(Continued on page 4)
10:30 – 12:00 pm  **Oral Abstract Session II**  
Moderators: Alice Ackerman, MD, MBA, FAAP & Richard Mink, MD, MACM, FAAP

10:30 am  Marek J. Grzeszczak, MD  
Effect of Clinical Practice Variation on the Outcomes of Diabetic Ketoacidosis in Children

10:45 am  Paul M. Jeziorczak, MD, MPH  
Glycyrrhizic Acid Does Not Reverse Micro particle-Induced Pulmonary Endothelial Permeability

11:00 am  Eliyahu C. Rosman, MD  
What Are We Missing? Arrhythmia Detection and Alarm Fatigue in the PICU

11:15 am  Simon Li, MD, MPH  
RSV Related Apnea – A Multicenter Regional Review of Incidence, Risk Factors, Outcomes

11:30 am  Brent Whittaker, MD  
Predicting Outcomes in Pediatric Blunt Trauma

11:45 – 1:00 pm  Lunch

1:00 – 1:10 pm  Educational Program - Introduction: Brad Poss, MD, MMM, FAAP  
*Treatment of Respiratory Failure: So Many Options*

1:10 – 2:00 pm  Non-Invasive Ventilation: Who Needs an Endotracheal Tube?  
Gerhard Wolf, MD

2:00 – 2:50 pm  Airway Pressure Release Ventilation: Take a Deep Breath and Hold!  
Ellie Hirshberg, MD

2:50 – 3:10 pm  Coffee Break

3:10 – 4:00 pm  Respiratory Failure Around the World: Ventilation with Limited Resources  
Niranjan “Tex” Kissoon, MD, FAAP

4:00 – 4:15 pm  Panel Discussion

4:15 – 4:30 pm  SOCC Business Meeting  
Donald Vernon, MD, FAAP, Chair

4:30 – 5:00 pm  Presentation of SOCC Distinguished Career Award  
Recipient: Niranjan Kissoon, MD, FAAP  
Presented by: Timothy Yeh, MD, FAAP

5:00 – 6:00 pm  Reception, Viewing of Posters, Abstract Awards (ROOM 346-347)

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**MONDAY, OCTOBER 22, 2012          8:30AM-11:30AM         CONVENTION CENTER ROOM 278**

8:30 – 8:45 am  Joint Program with Section on Emergency Medicine  
*Introduction: Brad Poss, MD, MMM, FAAP*

8:45 – 9:40 am  *Traumatic Brain Injury*  
Courtney Robertson, MD, FAAP

9:40 – 10:35 am  *Multi-Trauma Injuries*  
Adam Silverman, MD, FAAP

10:35 – 11:30 am  *Pediatric War Injuries*  
CAPT Jon Woods, MD, MC, USN
Join the Section on Critical Care (SOCC) for an exciting educational program, “Trauma in the ER, ICU, and Beyond”, co-sponsored by the Section on Emergency Medicine.

The program will help the attendee understand the challenges in caring for children with multiple traumatic injuries as well as the most recent evidence based care for traumatic brain injury. The final session will describe the pediatric traumatic injuries seen during war and how the military health system has had to adapt.

**PROGRAM SCHEDULE**

**Monday, October 22nd**

8:30–8:45 AM  
Introduction

8:45–9:40 AM  
Traumatic Brain Injury

9:40–10:35 AM  
Multi-Trauma Injuries

10:35–11:30 AM  
Pediatric War Injuries

The SOCC is also sponsoring a full day educational session on Sunday, October 21st including a session on the treatment of respiratory failure including two newer techniques, Non-Invasive Positive Pressure Ventilation and Airway Pressure Release Ventilation (H2022).

The final speaker on Sunday will be Niranjan “Tex” Kissoon, MD, FAAP who will be receiving the SOCC Distinguished Career Award. Dr Kissoon will discuss the treatment of respiratory failure in resource limited countries. Dr Kissoon has been instrumental in improving pediatric critical care around the world and played a lead role in the recent World Sepsis Declaration and the upcoming World Sepsis Day in September which has been endorsed by the American Academy of Pediatrics.

Section member LCDR Luke Zabrocki, MC, USN states, "A 12 year old girl with a severe penetrating head injury can be a challenging case for any pediatric intensivist. Staffing an ICU in a NATO hospital in Afghanistan makes this especially true. Here, the ballistics are from a high powered military grade weapon, the hospital is staffed by a single pediatric intensivist and a solo neurosurgeon, simple things such as serum osmolality tests and EEGs are unavailable, the patient is malnourished with intestinal parasites and drug resistant acinetobacter is a common occurrence. Doing more with less proves to be an essential skill. Yet somehow, this particular patient regained nearly all functional capacities.

Cultural considerations are no small part of the medical care. A ‘good outcome’ must be completely redefined for patients who have to return to a remote and very poor village. The role of the pediatric intensivist supporting military operations is truly challenging, encompassing the care of US and coalition troops, local national security forces, detainees, and local civilians. And just when my comfort zone has expanded to include all these new facets of medical care, the incoming rocket attack alarm causes me to scramble to find my true comfort zone, inside the closest bunker."

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**The Section on Critical Care**

The mission of the Section on Critical Care (SOCC) of the American Academy of Pediatrics is to optimize the care of critically ill infants, children, and adolescents through the educational and professional support of its nearly 800 members.

The SOCC sponsors educational programming and abstract presentations each year at the AAP National Conference & Exhibition as well as Pediatric Critical Care Coding, PICU Practice Management, and Preparing for Life in Academics courses.
The SOCC has established a new program to support members with 3 annual travel awards of $1,000 each. The grants are intended to support NCE travel-related expenses for pediatric critical care presenters, including trainees, with high scoring abstracts in the areas of education, safety, and quality. This year's recipient's are:

**Jonathan Byrnes, MD**
University of Arkansas
*Effect of Antithrombin Supplementation in Pediatric Cardiac Extracorporeal Membrane Oxygenation*

**Paul Jeziorczak, MD, MPH**
Children’s Hospital of Wisconsin
*Glycyrrhizic Acid Does Not Reverse Microparticle-Induced Pulmonary Endothelial Permeability*

**Katherine Slain, DO**
Akron Children’s Hospital
*Predicting Mortality in Pediatric Respiratory Failure: Feasibility of the Oxygenation Index Area Under the Curve*

In an effort to support research conducted by fellows and junior faculty, the SOCC initiated its Small Grants Program early this year. These one-year competitive grants of up to $3000 were instituted to promote research in education in Pediatric Critical Care Medicine and outcomes of quality and safety initiatives in the Intensive Care Unit.

As a condition of accepting the award, recipients are required to present their results at the AAP National Conference & Exhibition (NCE) the year following receipt of funds. Although individuals did not need to be an AAP SOCC member to apply, grants were awarded with preference to Section members. All applicants received a written critique of their proposal.

Numerous commendable proposals were evaluated in this inaugural year of the program. The Review Committee awarded two grants. **Jennifer York, MD**, a fellow at Washington University School of Medicine in St. Louis, received funding for her project entitled “Implementation of a Comprehensive Blood Conservation Program.” **Paul Dahm, MD**, a fellow from the UTHSC Medical School in Houston, received the other grant for his proposal “Improving Continuity of Care of Pediatric Sepsis Patients from Emergency Department Arrival through Pediatric Intensive Care Unit Admission.” We look forward to hearing these investigators present their results at the NCE in 2013!

**NIRANJAN “TEX” KISSOON, MD, FAAP**

This award recognizes an SOCC member and senior leader in the field of Pediatric Critical Care Medicine who has contributed to the subspecialty for 15 years or longer for significant career accomplishments.

The award will be presented to Dr Kissoon during the SOCC program on Sunday, October 21, 2012 at 4:30 pm during the AAP National Conference & Exhibition in Room 210 at the Ernest Morial Convention Center.
Richard Mink, MD, MAMD, FAAP

The Council of Pediatric Subspecialties, or CoPS, has had a very busy sixth year. First and foremost, a business plan was created that enables CoPS to continue its important role in promoting the activities of the pediatric subspecialties. This arose from a strategic plan created in January 2011 that led to the formation of a dues structure with four tiers of membership. One aspect of the development of this dues structure was clarification of the roles of the membership organizations. Based on a desire to ensure broad representation of the pediatric community, all of the dues-paying organizations will have voting representation within CoPS. In addition, effective July 1, 2012, payment of dues is required to maintain membership/representation with CoPS and to retain voting privileges.

CoPS has also improved its organizational structure by formalizing the process for selecting representatives and how issues are vetted from outside and within the organization. These and other items related to CoPS organizational structure are readily available on the CoPS website.

In conjunction with the Association of Pediatric Program Directors (APPD), the Academic Pediatric Association (APA) and the Council on Medical Student Education in Pediatrics (COMSEP), CoPS co-sponsored the highly successful bi-annual Pediatric Educational Excellence Across the Continuum (PEEAC) meeting held in September 2011. Plans are already underway for the 2013 meeting and CoPS looks forward to working with the APPD and other pediatric organizations on this endeavor.

One of the CoPS’ current projects is to work with the American Board of Pediatrics (ABP) on the Board’s Subspecialty Clinical Training and Certification Initiative (SCTC). When the Task Force examining this issue was formed in 2011, CoPS agreed to serve as the communications network for this important initiative. CoPS has been assisting the ABP in disseminating basic information and will soon be soliciting feedback from the pediatric subspecialty community about the Task Force recommendations. For more detail about the SCTC, visit the websites of CoPS (www.pedsubs.org) or the ABP (www.abp.org).

Finally, CoPS and the APPD are about to begin a joint project to examine “fellow readiness.” While the specifics are still being developed, it is hoped that this effort will provide information about the specific characteristics of a well prepared, beginning fellow. This will allow categorical program directors to tailor the curricula of the residents who plan to enter subspecialty training and make them better prepared for fellowship.

Otwell Timmons, MD, FAAP

Early in the last decade, the American Board of Pediatrics (ABP) developed a new maintenance of certification (MOC) process for diplomats in pediatrics and pediatric specialties. One element of MOC is life-long learning and self-assessment. The Section on Critical Care of the AAP approached the Pediatrics Review and Education Program to sponsor a self-assessment and board review series for pediatric intensivists. That publication, PREP-ICU, began its series of monthly on-line review questions in 2008. Now in its fifth year, PREP-ICU has over 550 subscribers. It is one of only three series approved for MOC credit by the ABP Critical Care Sub-Board. Its early success encouraged the Academy to develop a similar series in seven other subspecialties.

The content that PREP-ICU publishes consists of eight monthly case-based questions with educational critiques. The questions are written in board question format, and they cover specific Critical Care Sub-Board content specifications. Though not all 2500 content specifications can be covered in a publication cycle, the 17 major content headings are represented in proportion to their emphasis on the recertifying exam. Readers can choose between a learner mode and an exam mode, the latter of which simulates test-taking and readers have the option to re-take questions they have missed. Successful completion of a year of PREP-ICU earns 20 ABP MOC Part 2 points and 24 AMA PRA category 1 credits.

Much of the success of PREP-ICU comes from tireless volunteer work by an Advisory Board of accomplished ICU writers and educators. Prominent on the Board are senior textbook editors, department heads, division chiefs, and widely-published authors. Questions and critiques are submitted by Board members and edited in person by the entire Advisory Board. Questions are selected and edited to present evidence-based best practices and to reflect prevailing standards of care. Customer reviews of the quality of PREP-ICU have been excellent.

Interested readers can sample PREP-ICU questions and critiques at www.prepicu.aap.org. A year’s subscription costs $159 for Section members. Rates are slightly lower for in-training physicians and allied health personnel. Rates are higher for non-members of the Section and the AAP.

Keep current, earn credit, and test your knowledge of pediatric critical care with this quality, user-friendly PREP product.
On June 28, the U.S. Supreme Court announced one of its most highly anticipated decisions in decades: a 5-4 vote to uphold the constitutionality of the Affordable Care Act. The Court considered several challenges brought by states in *Florida et al v. Department of Health and Human Services*, and upheld the Affordable Care Act, ruling:

The Affordable Care Act’s individual mandate, while not valid under the Constitution’s Commerce Clause, is valid under Congress’s taxing authority; and the law’s Medicaid expansion to individuals earning about one-third more than the federal poverty level (FPL) is valid; however, its provisions allowing the federal government to withdraw Medicaid funding for states that fail to enact the expansion is not.

**What the Court Found**

At the centerpiece of the multi-state lawsuit against the Affordable Care Act’s individual mandate—which requires all legal U.S. residents to buy health insurance by Jan. 1, 2014, or pay a penalty—was the issue of states’ rights. Chief Justice Roberts, along with Justices Kennedy, Scalia, Thomas and Alito, rejected the federal government’s theory that the mandate was constitutional under the Commerce Clause. However, a different set of five Justices—the Chief Justice along with Justices Ginsburg, Breyer, Sotomayor and Kagan—agreed that it was constitutional because the mandate imposes a “tax” on people who do not buy health insurance, and Congress can impose that tax using its power to levy taxes. Though the mandate is intended to encourage people to buy health insurance rather than to raise federal funds, the Chief Justice still classified it (and its accompanying penalty) as a tax. The final issue before the Court was the law’s expansion of the Medicaid program (to individuals earning about $11,170 and families of four earning about $30,000). The Court found that Congress may offer states funding to expand Medicaid, and that states can agree to expand coverage in exchange for those new funds. If a state accepts the expansion funds, it must comply with the new rules and expand coverage, but—and this is the key underpinning of the decision—a state can refuse to participate in the expansion without losing other Medicaid funding. In other words, each state may choose to continue its current Medicaid program as-is.

The Affordable Care Act had assumed Congress could use its spending power to require states to expand Medicaid by threatening to withhold funds for the entire Medicaid program should a state fail to do so. The Court found this specific provision—by a vote of 7-2—“coercive,” and as a result, unconstitutional.

**What the Court’s Decision Means**

The AAP commended the Court’s decision to uphold the Affordable Care Act, and has been at the forefront of state and federal advocacy throughout the litigation process in support of the law’s continued implementation. While the ultimate fate of the law will depend on the outcome of the Nov. 6 Congressional and Presidential elections—with candidates from both political parties vowing to either overturn or uphold the law—the Supreme Court decision established a constitutional justification for protecting its gains for children and pediatricians.

Existing protections already in effect as part of the law’s implementation can therefore remain in place, and provisions set to take effect in the coming two years—such as an unprecedented increase in Medicaid payment rates to at least those of Medicare in 2013 and 2014 for certain primary care and immunization services—are on the path toward full implementation, unless Congress or the next administration changes the law.
The 19th Pediatric Critical Care Colloquium is being hosted by the Division of Critical Care Medicine, Children’s Hospital Los Angeles, at the Loews Santa Monica Beach Hotel, September 6-9, 2012. As many of you know, this is an outstanding informal meeting, unique to our subspecialty that began in 1986 and continues to evolve and remain popular for seasoned practitioners, faculty and trainees alike. The Colloquium offers a chance for dialogue and debate that larger meetings rarely are able to accommodate. This upcoming meeting promises sessions on timely and controversial topics, led by a superb faculty.

Plenary sessions will be held on lung injury, anesthesia and sedation, informatics, emerging models of care, the future of education in pediatric critical care and organ donation after circulatory determination of death. All will be designed for maximal audience participation, including a live audience response system. Optional workshops will include teaching leadership and professionalism and managing the difficult airway. Abstracts are welcome and eight will be chosen for oral presentation. PICU Jeopardy is back by popular acclaim, and challenging cases from around Los Angeles will be presented for discussion.

The meeting is designed to allow ample opportunity to explore Santa Monica and the greater Los Angeles area, with three full hours at midday of free time on Friday and Saturday. Warm yourself on the beach or by the magnificent pool; walk, run or bike along the miles of boardwalk; hike the nearby mountains; shop the trendy Third Street Promenade; visit Hollywood or play on the famous Santa Monica Pier. The Colloquium has not been held at a more exciting location in years!

All information, including registration and a link to hotel booking is available at our website (www.pcccolloquium.com). Feel free to contact us at any time for additional information.

Barry Markovitz, MD, MPH (bmarkovitz@chla.usc.edu)
SOCC NON-MEMBER SURVEY

The mission of The Section on Critical Care (SOCC) of the American Academy of Pediatrics (AAP) is to enable its nearly 700 members, who are interested in pediatric critical care, to meet for the purpose of discussing and developing ideas and generating programs and projects which will improve the care of infants, children and adolescents. There are 444 members of the AAP who are eligible to join the SOCC but have chosen not to be members at this time.

The SOCC Executive Committee surveyed these individuals during the month of April via Survey Monkey in an effort to improve the Section as well as generate additional interest in membership. All responses n=89 (20%) were anonymous.

The following is a short summary of a few of the questions and responses:

Are you aware of the Section on Critical Care of the American Academy of Pediatrics?

Yes-74%
No-26%

Why have you not joined the Section on Critical Care in the past? (Respondents were allowed to choose all applicable answers with top 5 answers shown)

I am already a member of other professional organizations-34%
The cost of Section membership is too high for the value-28%
I was not aware of the SOCC-23%
The overall educational programs at the AAP National Conference & Exhibition are not of interest to me-20%
I am already a member of other AAP Sections and chapters-19%

I would like to see the Section on Critical Care offer more educational programs focused on? (Respondents were allowed to choose all applicable answers with top 5 answers shown)

Cutting Edge Clinical Topics-65%
Quality Improvement and Patient Safety-49%
Resident and Fellow Education-28%
Translational Research-25%
Business Administration-22%

A few of the predominate themes that arose from the survey was the uncertainty of the value of joining the SOCC due to several reasons including: not being aware of the SOCC or its mission, how the SOCC distinguishes itself from the other critical care organizations, and declining CME budgets for many individuals. The Executive Committee feels that the SOCC is an important resource for providing a national voice to promote the care of critically ill children and is an extremely good value in these days of shrinking Continuing Medical Education budgets. Starting with this newsletter, and continuing over the coming months, you will hear about many of our efforts to enhance our educational programs as well as our support of critical care initiatives. We hope this succeeds in getting the word out and we would appreciate your help in telling a friend about why you joined the SOCC.

PEDiatric CRITICAL CARE SCIENTIST DEVELOPMENT PROGRAM

J. Michael Dean, MD, FAAP

The Pediatric Critical Care Scientist Development Program (PCCSDP) is a K12 funded by the Eunice Kennedy Shriver National Institute for Child Health and Human Development (NICHD) since 2004. It has funded over 20 highly qualified young faculty in pediatric critical care to help develop their scientific careers.

NIH grant funding is highly competitive, and even seasoned investigators with a long history of NIH funding have problems continuing to renew their grants. The purpose of a K award is to provide an extended period of support that will protect a young faculty member from the everyday duties of clinical care, teaching, and administration. It is almost impossible for a young investigator to become competitive in this arena unless he or she devotes a considerable amount of focused time on their research. K awards require 75% to 80% of guaranteed protection from non-research activities, and this time can then be used by the investigator to focus entirely on their research goals, publish papers about their research, and develop the necessary skills to become able to be independent investigators with their own R01, R21, or R03 grants from the NIH.

There are two phases to the five-year PCCSDP. In Phase One, lasting two years, Scholars receive financial support from the program while applying to the NIH for their own, independent K08 or K23 training award, or directly for their own R01 award. After a Scholar obtains their own K award, or at the end of two years (whichever is first), the Scholar then enters Phase Two for the remainder of the five years. In Phase Two, the Scholar is supported financially by their own grant or their department. During the application process, the Department Chairman makes a five year commitment to protect the Scholar even after the Phase One funding ceases. At the present time, the program has six Scholars in Phase One, and five Scholars in Phase Two.

Faculty scholars (board eligible or certified in Pediatric Critical Care) are normally within 5 years of their last fellowship training. The criteria by which applications are judged include the scientific potential of the individual, the institutional commitment to the investigator, the quality of the training plan, and the scientific importance of the research project that is included in the grant.

It is important that the investigator have a highly qualified funded mentor, as the quality of the mentor plays a major role in selection of Scholars. Full details about the application process are available on the website at www.pccsdp.org.

(Continued on page 11)
In addition to the written application due by October 1, the applicants must attend the annual research retreat that is held in Deer Valley, Utah on November 16 to 17, 2012. It is necessary to arrive in Utah on November 15 and depart of November 18 because the entire two day period (16th and 17th) is required for applicants. During this retreat, applicants will be interviewed by the National Advisory Committee, a group of experts who score the grant applications.

The field of pediatric critical care is extremely fortunate to have the opportunity for our young faculty to receive research support from this NICHD mechanism. Please encourage your young faculty (or yourself if you are in this category) to consider applying to our program.

In addition to the Scholar program that is funded by the PCCSDP, we have also embarked on a fellowship diversity program to attempt to increase diversity in pediatric critical care research. Limited funding is available for fellows from under-represented minorities to attend the research retreat, and have the opportunity to explore future research careers. Applications are available at www.pccsdp.org.

Finally, we are instituting a new program aimed at mid to late-career critical care faculty who may have had a long clinical career but are interested in pursuing funded research in the latter part of their careers. These individuals will participate in the research retreat in Deer Valley although there is no financial support available for these faculty to attend the retreat. Applications are available at www.pccsdp.org.

Brad Poss, MD, MMM, FAAP

The Roundtable on Critical Care Policy is a nonprofit organization whose goal is to provide a forum for leaders in critical care and public health to advance a common federal policy agenda designed to improve the quality, delivery and efficiency of critical care in the United States. The Roundtable was formed in 2009 and I was asked to serve as the American Academy of Pediatrics Section on Critical Care representative. I have subsequently been elected to the Board of Directors.

The Roundtable sponsors an annual National Summit on Critical Care Policy as well as Congressional Outreach Days during which Roundtable participants meet with Members of Congress and their staff to discuss issues important to the critical care community. The Roundtable currently has three working groups: Outcomes and Innovation; National Preparedness & Infrastructure; and Advanced Care (previously referred to as the End-of-Life Care working group). Dr Carley Riley, a member of the SOCC Executive Committee, is the new chair of the working group on Advanced Care and will provide a summary of the activities of that group with the next newsletter. The Roundtable has been active in advocating for National Institutes of Health funding and highlighting the need for increased focus on critical care related research as well as working with the Food and Drug Administration to raise awareness of the impact of the current drug shortages on critical care medicine.

I have been a part of the National Preparedness and Infrastructure working group whose focus is to ensure the prioritization of critical care in the nation’s emergency planning process. The Roundtable has been very active in helping to shape both the Senate and House versions of the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPA) which would bolster the nation’s ability to respond to a public health emergency. The Roundtable-endorsed provisions prioritize critical care within the federal government’s medical preparedness goals and improve resource awareness before, during and after an incident. More specifically, the legislation adds the critical care system to the National Health Security Strategy’s medical preparedness goals, thereby ensuring that critical care is included in federal, state and local planning efforts to increase preparedness for public health emergencies. The bill also requires the inclusion of medical surge capacity in the periodic evaluation of the nation’s preparedness capabilities, enabling an efficient and effective medical response during an emergency. The American Academy of Pediatrics was instrumental in ensuring that pediatric-specific provisions were included in the bill. Both the Senate and House have passed different versions of the PAHPA reauthorization legislation and now the differences must be reconciled through a conference committee. The Roundtable has been informed by committee staff that Congress will likely consider the final bill this fall.

For those interested in keeping updated on federal policy, the Roundtable offers a free weekly email summary which you can sign up for at their website, www.CriticalCareRoundtable.org. Past news summaries and additional information on the activities of The Roundtable on Critical Care Policy can also be found at the Roundtable website.
THE WORLD SEPSIS DAY—SEPTEMBER 13, 2012

Sepsis The most common, but least recognized disease

Sepsis is common and carries a high risk of death and long-term complications

Sepsis remains the primary cause of death from infection despite advances in modern medicine, including vaccines, antibiotics, and intensive care. Sepsis, which is often misunderstood by the public as “blood-poisoning” is one of the leading causes of death around the world. Sepsis arises when the body's response to an infection injures its own tissues and organs. It may lead to shock, multiple organ failure, and death, especially if not recognized early and treated promptly. Between one third and one half of patients with sepsis die.

In the developing world, sepsis accounts for 60-80% of lost lives per year in childhood, killing more than 6 million neonates and children yearly and is responsible for > 100,000 cases of maternal sepsis. Every hour, about 36 people die from sepsis.

Sepsis causes more deaths than prostate cancer, breast cancer and HIV/AIDS combined. Globally, an estimated 18 million cases of sepsis occurs each year. Experts in the field believe sepsis is actually responsible for the majority of the mortality associated with HIV/AIDS, malaria, pneumonia and other infections acquired in the community, in healthcare settings and by traumatic injury. Patients surviving sepsis have double the risk of death in the following 5 years compared with hospitalized controls and suffer from physical, cognitive and affective health problems.

Incidence is increasing dramatically

The incidence of sepsis is increasing dramatically, due to the ageing population and despite the advantages of modern medicine including vaccines, antibiotics and intensive care. Hospitalizations for sepsis have more than doubled over the last 10 years and have overtaken those for myocardial infarction in the US. International and national surveys indicate that 20-40% of sepsis patients that require treatment in the intensive care unit developed sepsis outside the hospital. The incidence of sepsis developing after surgery tripled.

The diagnosis of sepsis often is delayed

Sepsis is often diagnosed too late, because the clinical symptoms and laboratory signs that are currently used for the diagnosis of sepsis, like raised temperature, increased pulse or breathing rate, or white blood cell count are unspecific. In children, the signs and symptoms may be subtle and deterioration rapid. Sepsis is under-recognized and poorly understood due to confusion about its definition among patients and healthcare providers, lack of documentation of sepsis as a cause of death on death certificates, inadequate diagnostic tools, and inconsistent application of standardized clinical guidelines to treat sepsis.

Costs of sepsis are high and rising

An estimated $14.6 billion was spent on hospitalizations for sepsis in the US in 2008, and from 1997 through 2008, the inflation-adjusted aggregate costs for treating patients hospitalized for this condition increased on average annually by 11.9%. The costs related to long-term sequelae of sepsis are unknown. In Europe, it has been estimated that a typical episode of sepsis costs healthcare services approximately 25,000 Euros. Given the considerable loss of life years the human costs of sepsis are enormous.

World Sepsis Day is endorsed by the AAP.
For additional information, visit: www.world-sepsis-day.org
Drug shortages are quickly being realized as a national health safety issue with a potential to cause a nation-wide health crisis. The production of sterile injectable medications presents unique manufacturing difficulties and these medications make up the majority of drugs on the drug shortage list. The critical care and emergency medicine communities therefore are disproportionately affected by drug shortages.

In October of last year President Obama signed an executive order for the US Food and Drug Administration (FDA) and Department of Justice to work to reduce drug shortages and prevent price gauging. This was in part, a response to a three-fold increase in drug shortages from 2005 to 2010 from 61 to 178 per year. With early reporting of potential shortages by manufacturers and collaboration with the FDA, the reported number of drug shortages over the past 6 months fell to 42 from 90 one year earlier. Although encouraging, any limitations in the availability of medications used in the critical care setting can have a profound effect on patient care. Despite the executive order, manufacturers are still not required to report drug shortages unless they are the sole producer of a life-saving, medically necessary drug. Legislation has been proposed to change this but for now most notifications of drug shortages are purely voluntary.

In April of this year the Emergency Care Coordination Center (ECCC) within the Office of the Assistant Secretary for Preparedness and Response (ASPR) of the United States Department of Health and Human Services (HHS) hosted a meeting of stakeholders representing consumers, manufacturers, and regulators to discuss the impacts and potential solutions to this growing problem. The “Impact of the Drug Shortage on Emergency Care” meeting identified the following potential or currently utilized coping mechanisms to deal with ongoing drug shortages:

- Giving advanced notification of those drugs at imminent risk of shortage was noted as being an effective strategy.
- Extending expiry dates of drugs where possible.
- Utilizing alternative dosages.
- Importing drugs where safe and appropriate.
- Increasing reimbursement from CMS to incentivize the production of essential medications.
- Addressing government silos that have developed through regulation as a means of improving and expediting drug approval processes.
- Expanding FDA authority to identify and promote critical medications and manufacturing processes.
- Having FDA work with manufacturers to assist capacity building.
- Creating industry standards to prepare for future shortages.

A follow-up roundtable meeting was held this July to promote joint efforts towards short and long-term solutions. While awaiting federal and industry solutions, individual providers and medical administrators can help to mitigate the impact of drug shortages by reporting shortages to the FDA and the American Society of Health-System Pharmacists (ASHSP), by regularly monitoring the updated drug-shortage lists provided by these agencies and by taking efforts to alter ordering and prescribing practices for medications at risk of impending shortage.

The following is a partial list of some of the recent drug shortages affecting critical care. A complete and updated list can be found on the FDA and ASHSP websites (www.fda.gov / www.ashp.org).

- Atracurium Besylate
- Bumetanide Injection
- Bupivacaine Hydrochloride Injection
- 50% Dextrose Injection
- Diazepam Injection
- Epinephrine Injection 1:10,000
- Etomidate Injection
- Fentanyl Citrate Injection
- Fosphenytoin Sodium Injection
- Furosemide Injection
- Intravenous Fat Emulsion
- Ketorolac Injection
- Lorazepam Injection
- Magnesium Sulfate Injection
- Metoclopramide Injection
- Midazolam Injection
- Nalbuphine HCl Injection
- Ondansetron Injection
- Pancuronium Bromide Injection
- Phentolamine Mesylate
- Prochlorperazine Injection
- Promethazine Injection
- Propofol Injection
- Sodium Bicarbonate Injection
- Sodium Chloride 23.4%
- Sufentanil Citrate Injection
- SMX/TMP
- Vecuronium Injection
Pediatric Critical Care can be a lonely profession. There are those many nights with patients, families, nurses, fellows and house staff who are looking to you for answers with a child’s life hanging in the balance. And, compared to our adult colleagues, there are relatively few of us. You may wonder where those of us who practice pediatric critical care can turn to for support, advocacy, innovation and information.

I was initially elected to the SOCC Executive Committee in 2004 as the Critical Care Fellow representative. At that point, I honestly did not know what the role of the SOCC was or what role I could play in the Section. Additionally, I had never been a “joiner” and I am generally reluctant to become affiliated with groups that I do not fully understand. As I have come to find out, the AAP’s Section on Critical Care (SOCC) is an excellent resource for support, camaraderie and information.

As I complete my third term in the SOCC, I can honestly say that I have been pleasantly surprised and excited every step of the way. The SOCC’s most valuable resource is its members. I have met many people with whom I’ve shared (i.e. stolen) ideas to implement in my practice. I have gotten support from those with practice situations similar to my own as well as many whose practices were much different (“Wow, you need another partner!”).

I have learned from the best minds in our field whether established leaders or the up-and-coming generation. And, yes, I have kept abreast of the various employment opportunities if only to keep my current partners nervous enough to treat me well. Some may call this networking. I call it a reality check in a field where many of us do not have all of the access to our peers that we would like.

So, OK, you meet great people. What else does the SOCC have to offer? First, there is education. The SOCC has sponsored many educational offerings including the Scientific and Poster Sessions at the AAP NCE, Technologic Advances in the PICU, Critical Care Dilemmas and many more. Additionally, the SOCC awards grants to trainees and junior faculty to encourage groundbreaking critical care research and allow travel to the AAP NCE to present their findings. Furthermore, the SOCC has undertaken the development of a “roadmap” for maintenance of certification (MOC) in Pediatric Critical Care Medicine. Finally, the SOCC has been active at all levels of the AAP from review of policy statements, technical reports and clinical guidelines to participation in the Annual Leadership Forum (ALF).

But wait, there’s more! The SOCC Executive Committee has developed a new focus on wider inclusion of all SOCC members. This includes opportunities to serve on sub-committees to review abstracts, moderate Poster Sessions at the NCE and solicitation of contributions to the SOCC Newsletter. Furthermore, the SOCC is working towards being the home for research in quality, safety and education as shown by the Research and Travel grant initiative. Finally, the SOCC is collaborating with other organizations such as the SCCM, CoPS and WFPIICCS to ensure continued access to and improvement of pediatric critical care both domestically and around the world. Furthermore, the SOCC works to recognize those who have made outstanding contributions to our field. The SOCC Distinguished Career Award serves to highlight those who have made a positive and sustained impact on our profession through research, education and advocacy. Thus, SOCC members have frequent opportunities to interact with these “giants of our field” for advice, mentorship and inspiration.

Finally, by becoming a member of the SOCC, you become eligible for election to the SOCC Executive Committee. Committee membership gets you in on the “ground floor” for planning of educational sessions, policy statement/guideline review, collaboration with other AAP Sections, Award selections, abstract review (I learned a lot!) and the company of some of the most intelligent and devoted practitioners of Pediatric Critical Care. There is not a more interesting and interested group of people in our field. Advocacy, Research, Collaboration, Education, Quality and Leadership. I have seen for myself how the SOCC is advancing the practice of Pediatric Critical Care along all of these fronts. I have been surprised and excited by my participation in the SOCC. I hope that you will consider joining us in the SOCC.
What is the Section on Critical Care?

The American Academy of Pediatrics (AAP) Section on Critical Care (SOCC), founded in 1984, is the leading advocate for critically ill and injured children and a professional home for Pediatric Intensivists. Its mission is to optimize the care of critically ill and injured children of all ages through the educational and professional support of its members. The SOCC provides a forum for Pediatric Critical Care Specialists and other members to meet, discuss, and develop ideas, programs, and projects to improve the care of children and to address issues of importance to pediatric subspecialists.

Benefits of SOCC Membership:
* Advocacy (State & Federal)
* Educational Programs & Online Self-Assessment
* Scientific Abstracts, Research, Awards
* Policy Guidelines & Section Newsletters
* Leadership & Networking Opportunities
* Collaboration with other Organizations
* SOCC Members’ Only Website & Listserv
* Low Dues, Great Value!

How to Join?

It’s easy! Go to the AAP Member Center http://www.aap.org/moc/memberservices/sectionform.cfm (members only) to complete a fast-track online application or call AAP Membership at (800) 433-9016 ext 5897.

We welcome health professionals in a related field (registered nurses, nurse practitioners, respiratory therapists, and physician assistants) to fill out an online Affiliate Application http://www.aap.org/member/SectionMbrreq.htm. Affiliates, including international members, must be actively involved in some aspect of the study or care of critically ill, infants, children, or adolescents.

Annual dues are $10 for Residents, $30 for Affiliates, and $35 for all other member types.

Visit the SOCC website at http://www.aap.org/sections/critcare/default.cfm