Greetings SOID Members! I hope everyone is having a relaxing summer and getting a chance to enjoy being outdoors. It is hard to believe that Fall is just around the corner.

I would like to take this opportunity to welcome two new Infectious Diseases Fellows in Training to the SOID, Dr. Sophie Katz and Dr. Katie Richardson. Dr. Katz will join Dr. Adeline Koay as one of the two Training Fellow Liaisons on the Executive Committee. Dr. Katz is currently in her second year of fellowship at Vanderbilt University Medical Center in Nashville, Tennessee. Dr. Richardson is in her second year of fellowship at Children’s Mercy Hospital in Kansas City, Missouri and will be the Training Fellow Liaison to the Education Subcommittee. We look forward to their energy and ideas over the next two years. Welcome!

I am happy to share several updates regarding some of the education-related opportunities and programming from the SOID. First, the 2017 SOID Award for Lifetime Contribution in Infectious Diseases Education will be awarded to Dr. Meg Fisher at the Meet the Red Book Committee session at the AAP National Conference and Exhibition (NCE) in Chicago on Monday, September 18, 2017 at 8 AM. Please join us in recognizing and congratulating Dr. Fisher. Second, the 2017-18 S. Michael Marcy Visiting Professor Program has been awarded to Texas Tech University Health Science Center in Amarillo, Texas and Dr. Sheldon Kaplan from Baylor College of Medicine has graciously agreed to serve as the visiting professor. Stay tuned in early January for the 2018-19 call for applications. Third, a new PediaLink course, “Challenging Cases: Dengue, Chikungunya and Zika Virus Infections” was launched in June, 2017. We hope that you will take advantage of this practical and timely 30-minute course and share this information with your colleagues. Other courses of...
Chair’s Letter Continued from Page 1

interest can be viewed on the SOID website. Also, check out the recently published CDC Updated Guidance for Healthcare Providers Caring for Pregnant Women with Possible Zika Virus Exposure article in the July 24, 2017 issue of the MMWR.

I want to again thank the 2017 PREP ID Planning Group Co-Chairs, Lilly Immergluck and Lorry Rubin and members, Lara Danziger-Isakov, Bob Frenck, Angela Myers and Debra Palazzi for their time and commitment in planning and implementing the 2017 PREP ID: A Comprehensive Update of Pediatric Infectious Diseases and Antimicrobial Therapy live course which is co-sponsored by the SOID and the Pediatric Infectious Diseases Society. There were 195 attendees at the course which was held on July 27-30, 2017 in Dallas, Texas. We appreciated the partnership with the editors of the Nelson’s Pediatric Antimicrobial Therapy book regarding course content and the opportunity to have Dr. John Nelson provide a historical perspective on antimicrobial development.

At the 2017 NCE, the Section will be offering a focused educational program entitled, “You be the Judge: Why and How to be Smart with Antibiotic Prescribing in Primary Care”. Faculty members, Drs. Jason Newland, Julia Szymczak, and Rita Mangione-Smith will engage pediatricians in a discussion about issues and solutions around practice-based antimicrobial stewardship. Don’t miss this great opportunity to discuss with the faculty some of the issues that you face.

August is National Immunization Awareness Month (NIAM) which highlights the importance of vaccinations for people of all ages and encourages individuals to check to make sure their immunizations and those of their family members are up to date. This further emphasizes the role that we play as healthcare providers to ensure that the immunizations of our patients are up to date. This is especially important for the adolescents who we provide care for, given the less than optimal rates of adolescent vaccination for various vaccines. To help the practitioner remember that additional vaccine doses should be given in late adolescence, the CDC has changed the look of the immunization schedule highlighting the 16-18 year old age group. It is hoped that this will remind practitioners to review the immunization records of this older group of adolescents and ensure that they receive all the vaccine doses that they need. Please see the resources developed by the AAP for pediatricians for NAIM.

Finally, the SOID is fortunate to have so many who are willing to volunteer their time and expertise. The Executive Committee wishes to extend a special thank you to Dr. Chris Harrison for his long-time support of the newsletter through his 28 (with this edition) ID Pearl articles dating back to 2004. He has addressed a wide range of interesting topics in a practical case-based format. We look forward to many more articles in the future!

I encourage you to spread the word to your colleagues who may have an interest in the SOID and its activities to join the Section. I would also like to encourage all members who are interested in serving in the SOID on educational issues or who have suggestions for educational topics, website issues or the newsletter subcommittees to please contact us or complete the 8-question expertise and interest survey.

I very much look forward to receiving your ideas and suggestions as we go forth and thank you for your continuing interest and membership in the SOID. Please don’t hesitate to contact Suzanne Kirkwood, the SOID manager and staff liaison at the AAP (SKirkwood@aap.org) or myself (ttan@northwestern.edu) to let us know how we can best serve your needs.

Best wishes for a wonderful Fall and Winter.

Respectfully,
Tina Q. Tan, M.D., FAAP, FPIDS, FIDSA

From the ACIP Meeting of June, 2017

The slide sets and minutes of the June 21-22, 2017 meeting are available here. The next ACIP meeting is scheduled for October 25-26, 2017.
Section on Infectious Diseases Award for Lifetime Contribution In Infectious Diseases Education

This award is given annually to an Academy member who has made outstanding contributions to education in infectious diseases. The candidate’s contribution is indicative of a substantial long-term dedication to the highest ideals of education. This year we are pleased to present the award to Dr. Margaret Fisher.

Dr. Fisher is presently a Professor of Pediatrics at Drexel University College of Medicine in Philadelphia and at St. George’s University School of Medicine in Grenada. She is the Chair of the Department of Pediatrics at Monmouth Medical Center (MMC) and Medical Director at The Unterberg Children’s Hospital at MMC.

Dr. Fisher has been an active AAP member and leader since 1982, which is demonstrated by her participation and leadership in many groups including: Chair, New Jersey Chapter of the AAP; Chair, Section on Infectious Diseases; Member, Committee on Infectious Diseases; Co-Chair, PREP ID Planning Group; Chair, PREP the Course Planning Group; Member, Committee on Continuing Medical Education; Chair, AAP Global Immunization Advocacy Project Advisory Committee; Member, COID Emerging Infections and Outbreaks Subcommittee. Dr Fisher has also made significant contributions as a member of the AAP Disaster Preparedness Advisory Council, including serving on writing teams for the AAP anthrax and smallpox clinical guidance and developing an inaugural pediatric preparedness tabletop and virtual exercise. This list does not include all her participation within a wide variety of state, university, medical school, hospital and society positions and roles.

Dr. Fisher is a very much sought after speaker locally, nationally and internationally which is reflected by the innumerable meetings at which she has spoken. She is a long-standing member of the NCE faculty and is able to address an incredibly wide breadth of topics. Dr. Fisher provides practical and useful information to pediatricians, conveying it in a very engaging way. She always receives outstanding evaluations and her teaching skills are further evidenced by the many honors and teaching awards she has received over the years. Additionally, Dr. Fisher has co-authored over 150 peer-reviewed articles, chapters, books, abstracts and other publications and teaching tools. Finally, Dr. Fisher served as the visiting professor for the inaugural SOID S. Michael Marcy Visiting Professor Program which was held in June, 2016. It is through these opportunities and interactions in daily practice with medical students, residents and fellows that Dr. Fisher’s role as a master teacher and clinician shines.

For these reasons, the SOID Executive Committee feels that Dr. Margaret Fisher is most deserving of the 2017 Lifetime Contribution in Infectious Diseases Education Award.

Please join us in congratulating Dr. Fisher on her award!

The award presentation for Dr. Fisher will be held at the Meet the Red Book Committee session (session S3018) on Monday, September 18, 2017 at 8:00 am at the AAP National Conference and Exhibition in the McCormick Place Convention Center W190 A.

Welcome to our New SOID Members

If you know of others who might be interested in joining the Academy and the Section please have them call 1-800-433-9016 ext 5885 or go to www.aap.org. The “Become A Member” link will take them to an application. Current Academy members may join the Section here (member ID and login required). You may also call AAP Customer Services at: 866-843-2271.
Welcome to Our New Training Fellow Liaisons

Sophie Katz, MD, FAAP received her undergraduate degree in biology from the College of Charleston in South Carolina and her medical degree from Louisiana State Health Sciences Center in Shreveport, Louisiana. She completed three years of pediatric residency training, followed by one year as Chief Resident at St. Christopher’s Hospital for Children in Philadelphia, Pennsylvania. As chief resident, she worked as a general pediatrician in both the inpatient and outpatient settings and began to develop an interest in antimicrobial stewardship, quality improvement, and improving healthcare on a population level. Currently, Dr. Katz is a second-year pediatric infectious diseases fellow at Vanderbilt University Medical Center. Her postdoctoral research is focused primarily on biomarker development, focusing first on procalcitonin levels and kinetics across children of various ages and infectious processes, as well as its implications for enhancing antimicrobial stewardship efforts. Dr. Katz will be pursuing a Masters of Public Health starting in the fall of 2017. Dr. Katz will serve on the SOID Executive Committee through June, 2019.

Katherine Richardson, MD, FAAP received her undergraduate degree in music from Wheaton College and her medical degree from Penn State College of Medicine. She completed 3 years of pediatric residency training at East Carolina University, Vidant Medical Center in Greenville, North Carolina. Dr. Richardson is currently a second-year infectious disease fellow at Children’s Mercy Hospital in Kansas City, Missouri. She first became interested in education in residency with regular opportunities in educating residents and medical students. She is especially interested in education in the global health setting. Her interest in teaching has continued in her current research which involves understanding the use of clinical decision aides by residents and faculty in the setting of caring for febrile infants. Katie’s hope is that this research will translate on a global scale to be used as teaching tool and decision aide in resource limited countries. She has co-authored a book chapter on Fever of Unknown Origin which will be published in Pediatric Infectious Diseases later this year. Additionally, Katie was selected among a highly competitive group to present a rare case of endophthalmitis at Pediatric Fellows’ Day at IDWEEK this year.

ID Training Fellows Column:
Navigating opportunities during medical training

Special article for our new medical student members and residents

Wei Li A. Koay, MBBS, MSc, FAAP
Johns Hopkins University, Baltimore, MD

From medical school applications to finding a job after residency or fellowship, medical training is full of countless possibilities that can lead one down any number of paths. As you progress through training, you will have many opportunities. The key is learning to seize these opportunities whilst also balancing your priorities and achieving your desired goals. The choices we make in medicine guide our career path, whether it is in patient care, research, public health, administration, or other paths.

Choosing a specialty or subspecialty
In the U.S., there are over 120 specialties and subspecialties within medicine, about 20 of which are pediatric-related. Some people enter medical school knowing exactly what they want to specialize in, while others start to form a preference later in their training. Selecting your electives carefully and finding good mentors are essential in helping you to make this decision. The mentor(s) you select not only has an effect on the type of residency and fellowship that doctors select, but has also been associated with career satisfaction. The American Academy of Pediatrics (AAP) Mentorship Program offers the chance for those interested in pediatrics to find a mentor or connect with mentees.

By identifying your interests and areas of excellence, you may start to make a short-list of your preferred specialty or subspecialty. The Association of American Medical Colleges (AAMC) provides access via “Careers in Medicine” to several self-assessments that can help trainees to identify specialties that suit your interests and skills. Some other factors to consider when choosing a specialty include your preference for research and clinical procedures, length of training, work-life balance, family commitments, earning potential and future job opportunities.
Preparedness of residents for fellowship

The primary goal of residency is to provide trainees with the foundation needed to succeed in their chosen career, including advanced subspecialty training. In pediatrics, nearly one-third of graduating residents enter a fellowship training program. Surveys conducted in surgery, obstetrics and gynecology and pediatrics revealed that, according to fellowship directors, few incoming fellows are well-prepared for subspecialty fellowship training. The reasons behind such deficiencies are unclear, but two areas that residents should focus on during residency include; clinical proficiency and academic scholarship. Specifically, for pediatrics, the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Pediatrics (ABP) require that residents are competent in a number of clinical procedures, and also participate in a scholarly activity. Depending on your choice of practice in the future, residents should be proactive in seeking out opportunities to become proficient in procedures, as opposed to simply meeting the basic requirements. Expressing an interest to other healthcare professionals from whom you would like to learn a specific skill will result in a higher likelihood for learning opportunities. In addition, selecting electives in your area of interest and participating in a research team are also beneficial in preparing residents for fellowship.

Conferences and Publications

Attending conferences as a medical student or resident, whether as an attendee or a presenter, can be a great opportunity to broaden your horizons, listen to renowned speakers, develop your network contacts and present your research. Most conferences have discounted registration fees and financial assistance available for students and residents. One example of this is the AAP National Convention and Exhibition which takes place annually, with a travel grant available by the Section on Infectious Diseases for residents or fellows in training with an interest in infectious diseases.

Apart from attending medical conferences, having a publication can add value to your training experience. Although not essential, getting published as a physician-in-training can not only build up your resumé, but is also a chance for trainees to submit their research and become well-versed in their area of interest. Trainees also can be on the look-out for unique and unusual cases that can be published as case reports or series. Table 1 shows a short list of journals that are particularly encouraging for trainees or less experienced writers.

Table 1. Publications for newcomers in publishing

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<thead>
<tr>
<th>Journal name (click for submission guidelines)</th>
<th>Background</th>
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<tbody>
<tr>
<td><strong>The American Medical Student Research Journal</strong></td>
<td>For students who are future physician-scientists. Accepts basic science research, case reports, personal experience essays</td>
</tr>
<tr>
<td><strong>Student BMJ</strong></td>
<td>Accepts articles by medical students, junior doctors, experts and journalists. They have a specific list of topics which they accept.</td>
</tr>
<tr>
<td><strong>Harvard Public Health Review</strong></td>
<td>Accepts submissions from students and faculty across academic disciplines, mainly focusing on current public health issues.</td>
</tr>
<tr>
<td><strong>Journal of Graduate Medical Education</strong></td>
<td>This journal focuses on the education of medical residents and fellows, and the environment in which they learn.</td>
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Seeking leadership roles during training

Leadership skills are becoming increasingly essential in medicine, with evidence that clinical leadership results in the improvement of health services and teamwork. Honing your leadership and team-building skills can be achieved through the roles you perform on a daily basis during rounds and other patient care activities. Leadership roles in medicine can also present themselves in administrative and advocacy settings.

Time constraints or lack of experience may make trainees wary of “official” leadership positions. However, the skills and networks gained from such responsibilities can open doors to other opportunities. Numerous leadership positions exist for trainees within several medical associations, including the American Medical Association and the AAP. For those who are interested, the AAP Section on

Continued on Page 6
Pediatric Trainees has available leadership opportunities for medical students and residents. Several other Sections within the AAP also have leadership opportunities for trainees and early career physicians.

Being flexible
Finally, two words of advice that you will often hear is: “be flexible”. Sometimes, things may not turn out as you planned, or may not be as successful as you envisioned. It is okay to work things out through trial and error, and adjust your plans according to the situation. Remember to organize your time wisely, avoid over-committing, and be willing to seize opportunities that may be outside your comfort zone. It will be a growing opportunity and you will be glad that you have stretched yourself.

References:

FYI: Accessing the SOID Website

The easiest way to access the SOID website is to save it as a favorite (Internet Explorer) or bookmark it (Firefox) on your computer. Go to the SOID webpage at: https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Section-on-infectious-diseases/Pages/default.aspx For Internet Explorer, click on favorites and then add to favorites.

The latest edition of the AAP Academic and Subspecialty Advocacy Washington Report is now available (AAP login and password required). The report details the important advocacy work that the Academy is engaging in and highlights issues of particular importance to medical and surgical subspecialty pediatricians. The report includes updates on AAP advocacy efforts to protect Medicaid from cuts, extend the Children’s Health Insurance Program, promote pediatric subspecialty workforce issues, increase funding for pediatric research, and improve drugs and medical devices for children, among many other issues. The report also has a new feature: a new one-page executive summary for a quick overview of the latest information.

Review of the Recent Infectious Disease Literature

These summaries and commentaries are completed by volunteer Contributing Editors from the SOID. Each is responsible for reviewing the current infectious disease literature for several journals. They select an interesting article and present it for your review to help keep you current on various issues.


Reviewed by: Sherman J. Alter, MD. Division of infectious Disease, Dayton Children’s Hospital, Department of Pediatrics, Wright State University Boonshoft School of Medicine, Dayton, OH.

Rotavirus (RV) is the most common cause of severe diarrhea in young children throughout the world. Over 500,000 children aged <5 years die each year from rotavirus infections. Most of these children live in low-income countries, including those in sub-Saharan Africa and Asia. RV vaccines are an important component of a strategy to decrease severe RV-associated gastroenteritis (GE) and child mortality. Vaccination is recommended in all national immunization programs and strongly recommended in countries where deaths from diarrhea are high among young children.

Conducted in Niger, this trial was a double-blind, placebo-controlled, randomized, phase 3 investigation of a live, bovine-human reassortant vaccine containing RV serotypes G1, G2, G3, G4, and G9 (BRV-PV, Serum Institute of India). Placebo utilized the same formulation without viral antigens. The vaccine was previously demonstrated to be stable for 2 years at a temperature of 37° C and for 6 months at 40° C. While initially transported to the country under cold-chain, both BRV-PV and placebo were stored at temperatures not exceeding 25° C and, after distribution, at ambient temperatures until administered. Healthy infants received three doses of vaccine or placebo orally at 6, 10, and 14 weeks of age. Children received all other vaccines that were routinely recommended. The primary endpoint was the efficacy of three doses of BRV-PV versus placebo against a first episode of laboratory-confirmed severe RV GE (Vesikari score≥11) beginning 28 days after dose 3.

A total of 3508 infants were included in the per-protocol group (1780 BRV-PV, 1728 placebo). Infant characteristics were similar at baseline in the two groups. Severe RV GE was reported in 31 infants in the vaccine group and in 87 placebo recipients, resulting in a per-protocol vaccine efficacy (VE) of 66.7% (95% CI, 49.9 to 77.9). RV vaccine prevented 4.30 (95% CI, 2.75 to 5.85) episodes of severe RV GE per 100 person-years. In the intention-to-treat group (infants who received at least one dose of vaccine or placebo), severe RV GE was reported in 35 infants in the BRV-PV group and 125 in the placebo group resulting in a VE of 69.1% (95% CI, 55.0 to 78.7). Adverse events were similar in the two groups (P>0.15). Fewer serious adverse events were noted in the vaccine group. There were no significant differences in mortality from the time of the administration of the first dose of vaccine until the child reached 2 years of age between the BRV-PV group and the placebo group (27 BRV-PV and 22 placebo, P=0.48).

Reviewer’s Commentary:

Two safe and effective oral, live, attenuated RV vaccines, Rotarix (attenuated G1P8 RV, GlaxoSmithKline) and RotaTeq, (pentavalent human-bovine reassortant RVs, Merck) are available internationally. The World Health Organization recommends that infant RV vaccines

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should be included in all national immunization programs. These vaccines are procured by UNICEF through financing mechanisms of the Global Alliance for Vaccines and Immunizations (GAVI).³

This study performed in an impoverished setting in Niger documents the safety and efficacy of a low-cost, oral RV vaccine (BPV-PV). Being relatively thermostable, BPV-PV may provide an advantage in remote settings where cold-chain capacity is limited. It will be important to both perform genotypic analyses of circulating RV serotypes after introduction of BPB-PV and additional large-scale surveillance of adverse events among vaccinees. However, the availability of a low cost, safe and effective RV vaccine will enhance the overall supply of vaccines to further decrease morbidity and mortality among young children.

References:


Reviewed by: Jane Gould, MD, FAAP, Associate Professor of Pediatrics, Drexel University College of Medicine, Hospital Epidemiologist, Attending Physician, Section of Infectious Diseases, St. Christopher’s Hospital for Children, Philadelphia, PA.

This retrospective study of blastomycosis in Wisconsin children, aged 0 to 18 years of age, is the first large scale review of pediatric cases in the U.S. It was performed to describe the clinical and epidemiologic features in children as well as to identify which Blastomyces genotype predominates and how the genotype might affect the clinical presentation, duration and severity of illness or time to diagnosis in children. The results of this study are especially helpful for pediatric providers who practice in endemic areas to ensure they maintain a high index of suspicion for blastomycosis. It is also a reminder of those who do not practice in such settings to consider blastomycosis in symptomatic pediatric patients who have traveled to endemic areas especially if they also participated in high risk activities such as camping, fishing or hiking. Blastomycosis can be a serious, life threatening infection in children.

The investigators collected data from both the Marshfield Clinic Health System and the Wisconsin Department of Public Health from 1999-2014 and 2004-2014 respectively. The diagnosis was confirmed as disease if the patient’s clinically compatible syndrome had Blastomyces identified in culture or had evidence of broad budding yeast on histopathology or smear. They identified 114 confirmed pediatric patients which were then classified as having pulmonary or extrapulmonary disease. Clinical, laboratory and radiographic findings were compared between pulmonary and extrapulmonary disease cases. The mean age of all cases was 12.9 +/- 4.6 years with the youngest patient being 5 months old. The majority of cases had isolated pulmonary disease, followed by combined pulmonary and extrapulmonary disease. The extrapulmonary cases were primarily skin and bone disease. Underlying medical conditions were identified in 24.6% of the patients. Age, gender and frequency of underlying medical conditions did not differ significantly between isolated pulmonary and extrapulmonary disease. Patients with isolated pulmonary disease were significantly more likely to be Asian than patients with extrapulmonary disease. Isolated pulmonary cases were more likely to have fever, a higher WBC at presentation and during hospitalization, as well as higher C-reactive protein level. Chest radiographs most often demonstrated infiltrates or an effusion. Patients with extrapulmonary were more likely to undergo surgery mostly for biopsy than those with isolated pulmonary disease. The median length from symptom onset to start of antifungal treatment was 19 days and was longer among patients with extrapulmonary disease (15.0 vs 46.5 days, P<.01). The median length from symptom onset to resolution of illness was 153.0 days and was longer for patients with extrapulmonary disease (140.0 vs 184.0 days; P<.01). Antifungal medications and lengths of treatment did not differ between the groups with median length of treatment of 140.0 days. There was a 4.4% death rate and each death occurred in isolated pulmonary cases secondary to respiratory failure.

Reviewer’s Commentary:
Fifty-two of the isolates were available for genotyping by microsatellite typing and species typing by internal transcribed spacer2 (its2) sequencing. Two main genetic groups were identified; B. gilchristii and B. dermatitidis. B. gilchristii was the organism identified in
92% of isolates (which is different than in adults where only 56% of isolates were B. gilchristii). The significance of this finding is uncertain. Additionally, B. gilchristii was more likely to cause isolated pulmonary disease whereas B. dermatitidis was more likely to cause extrapulmonary disease.

References:

**Greenhow TL, Hung YY, Herz A. Bacteremia in children 3 to 36 months old after introduction of conjugated pneumococcal vaccines.** *Pediatrics* 2017; 139: e20162098

**Reviewed by:** Stephen C. Aronoff, MD FAAP, Temple University School of Medicine.

The authors reviewed the results of all blood cultures obtained in the emergency room and from the first 24 hours of hospitalization collected between 9/1/1998 and 8/31/2016 from children aged 3-36 months who were part of Kaiser Permanente of northern California. Exclusion criteria included underlying immunoincompetence, oncologic disorders, known genetic disorders, and central venous catheters. Extracted variables included sex, birth and visit date, site of blood collection, receipt of either the 7- or 13-valent (PCV13) conjugate pneumococcal vaccine, urinalysis and blood culture results. The 7-valent vaccine was introduced in April 2000 and the 13-valent vaccine in June, 2010. Cultures that yielded suspected contaminants were excluded from the report.

During the study period, the annual population of 3-36 month children ranged from 94,269 to 103,474 (mean = 98,447’ SD = 2640). Of 57,733 blood cultures obtained from subjects who met inclusion criteria, 538 (1%) yielded a pathogen. The rate of bacteremia decreased from 97 /100,000 children (95%CI: 79.4-117) in the pre-vaccine period to 21/100,000 children (95%CI: 13.5 – 30.3) after the introduction of PCV13. Contamination rates were 100/100,000 (95%CI: 82.1-120) and 45/100,000 (95%CI: 33-59.8), for the two time periods, respectively. Following the introduction of PCV13, *E. coli*, *Salmonella* species, and *S. aureus* accounted for 77% of the isolates. Urinary tract infections accompanied 93% of the episodes of *E. coli* bacteremia. Overall, 24% of bacteremic episodes occurred in the absence of a focus of infection; the incidence rate of bacteremia without focus was 5/100,000 in the post- PCV13 era.

**Reviewer’s Commentary:**
Occult bacteremia (bacteremia without a focus) in children aged 3-36 months was described in multiple studies from the 1970’s, estimated incidence rates ranged from 3-11%. Among children in this age group with fevers exceeding 39°C, the probability of bacteremia was estimated at 0.43. *S. pneumoniae*, *H. influenzae* type b and *N. meningiditis* accounted for 85%, 10% and 3% or episodes respectively. In these children with occult bacteremia, the risks of persistent bacteremia and subsequent meningitis were estimated at 21% and 9% respectively. A management algorithm recommended empiric antibiotic therapy, follow up cultures in 24-48 hours and admission and treatment for all children with persistent bacteremia.

The advent of conjugated vaccines, first HIB and now PCV13, has eliminated the term “occult bacteremia” from the modern pediatrician’s lexicon. The present study demonstrates the effect of these vaccines. *Streptococcus pneumoniae* is no longer a significant cause of bacteremia in this age group. The incidence of bacteremia is almost 1000-fold less than it was. Finally, the vast majority of cases of bacteremia among febrile children aged 3 to 36 months are accompanied by signs and symptoms of focal infection.

In spite of all of this good news, a degree of vigilance is still required. Young children who are febrile need to be closely examined for signs and symptoms of localized infection and their vaccination histories need to be closely reviewed. Consider blood cultures, a complete blood count and differential, urinalysis, and perhaps empiric antimicrobial therapy in unvaccinated children; close follow-up is required. For vaccinated patients, a urinalysis is helpful, given that *E. coli* is the most common cause of bacteremia and most of these cases are accompanied by a urinary tract infection. *Salmonella* infections can result from foodstuffs but acquisition from reptiles is particularly likely in children with Salmonella who are less than 5 years of age. As such, exposure to reptiles is a critical part of the history in these cases. Finally, bacteremia should be considered in febrile children aged 3-36 months with pneumonia, gastroenteritis, osteomyelitis and complicated skin and soft tissue infections.
Review of the Recent Infectious Disease Literature  Continued from Page 9

References:

Policy Highlights from the Committee on Infectious Diseases (COID)

AAP statements under development or revision
1. Elimination of perinatal hepatitis B – providing the birth dose within 24 hours
2. Infection Prevention and Control in Pediatric Ambulatory Setting
3. Infection Control in Organized Sports
4. Antimicrobial Stewardship in Hospitals
5. Chemical-Biological Terrorism and Its Impact on Children
6. Management of Neonates with Suspected or Proven Early-Onset Bacterial Sepsis
7. Recommendations for Prevention and Control of Influenza in Children, 2017-18

The following AAP clinical practice guidelines are in the process of development:
1. Fever in Infants Under 3 Months of Age

Guidelines in Progress with External Organizations
1. HICPAC is working on a guideline for prevention of infections among patients in neonatal intensive care units (NICU)
2. Diagnosis and Management of Bone and Joint Infections (IDSA/PIDS)
3. Clinical Guidelines for Diagnosis and Antiviral Management of Seasonal and Pandemic Influenza in Adults and Children (IDSA)
4. Infectious Diseases Society of America (IDSA), the American Academy of Neurology Institute (AANI) and the American College of Rheumatology (ACR) clinical practice guideline on Lyme Disease
   a. Subcommittee on Babesiosis
5. Clinical Practice Guidelines Practice Guidelines for Outpatient Parenteral Antimicrobial Therapy (IDSA)

SOID Travel Grant Awards

One of the roles of the SOID is to promote the education of those physicians interested in infectious diseases. We are pleased to be able to offer travel grants to AAP members who are residents with an interest in infectious diseases and ID fellows in training. In years when the PREP ID course is held, these travel grants are offered to PID fellows-in-training who are AAP/SOID members and will be taking the certifying boards in that year. The following recipients were selected by lottery and received $1,000 to defer travel expenses related to attendance at the 2017 PREP ID course held in Dallas, Texas this past July.

<table>
<thead>
<tr>
<th>Katherine Ebsworth-Mojica, MD</th>
<th>Sindhu Mohandas, MD, FAAP</th>
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<tr>
<td>University of Rochester Medical Center, Rochester, NY</td>
<td>Children’s Hospital of Montefiore, Bronx, NY</td>
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<tr>
<td>Candace Johnson, MD</td>
<td></td>
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<td>Columbia University Medical Center, New York, NY</td>
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Continuing Challenges of Transition of Care in Adolescents and Young Adults with HIV

Michael Bolaris, MD
Pediatric and Adult Infectious Disease
Pediatric HIV Director, Antimicrobial Stewardship Director
Harbor-UCLA Medical Center

I walked into the room to say goodbye—there lay my 25-year-old patient, whom I had been caring for over the last 5 years. She had been one of my most challenging patients, both during my fellowship training and now as her primary care giver. It had been one adventure after another.

She was diagnosed with HIV at 6-years-old. Her father succumbed to an opportunistic infection while on home hospice. The patient’s younger sister had not been infected; her mother had been adherent to therapy. My patient had developed severe pancreatitis from either didanosine or stavudine, which were components of her initial regimen. We managed her through cryptococcal meningitis, primary CNS lymphoma, persistent Mycobacterium avium infection, and numerous other opportunistic infections. Now, she lay dying from diffuse large B-cell lymphoma, her second HIV-associated malignancy in the span of 5 years. Her mother refused home hospice after already having done that once before, with the patient’s father.

I tried persistently to get her to take her meds, simplified her regimen to 1 pill once a day, incorporated mental health evaluations and family members had tried directly observed therapy. There had been glimmers of hope, such as her successfully maintaining a relationship with a boyfriend for a year. She hoped to go to school to be a teacher. Despite that, discounting a brief period immediately after her CNS lymphoma while hospitalized, she lived most of her life with uncontrolled AIDS. I had offered her transition to adult care, but she refused, wanting to stay with the providers she knew.

Transitions of care for young adults like my patient present significant challenges to the pediatric and adult providers. Projections suggest 25,000 adolescents, both those controlled and uncontrolled, will require transition to adult HIV providers in the coming decade.1 The CDC also estimates that approximately 61,000 youths are infected with HIV, with the majority undiagnosed.2 While many of these patients may meet chronologic age for transition, other factors, including psychological, social, and developmental, and patient preference, pose major challenges to transitions of care, especially in those adolescents and young adults with perinatal infection.3,4

Prior to my tenure as Pediatric HIV Director at my institution, we routinely transferred our patients to the Adult HIV providers at or around the age of 21 or sooner, depending on the readiness of the adolescent. To date, our experience has confirmed the necessity of a formalized well-developed process for transition as recommended by AAP and others including transition planning and discussions with the patient and family with significant lead time.1,3,5 We give adolescents time to understand their medical conditions, prepare them for the expected changes in care, help them to develop skills to navigate the complexity of the medical system, assure continued coverage for medications, and we provide a detailed medical history to the patient and to the adult clinics.4–6 We also gently discuss the changing dynamics and/or availability of insurance and other supports as they “age out” of programs that target children.

Data have suggested that patients who acquired HIV infection through mother-to-child transmission have a harder time transitioning to adult care, although not all studies agree.7–10 In addition, the published success of the transition varies with the metric used. For example, Kakkar et al. found significant decline in patients with a CD4 count >500 cells/mm3 after transition of care, albeit with a small number of patients.9 Judd et al. found that CD4 counts improved in some populations but were worse in others after transfer.10 Rates of the durability of care seems to be low as well, with only about 50% of patients transitioned to adult care remaining engaged in care. These numbers seem to mirror some of the data seen in newly diagnosed patients in which only about 40% of patients engaged in care overall.11 These numbers are disappointing but not unique to HIV.12

In my experience, our team has experienced difficulties and success with transitioning patients. Moving forward, for some of these patients who are reluctant to transition, or that have other major developmental or chronic medical conditions, I have opted to build a transitional care clinic. This has allowed me to offer care to both adolescents and young adults with HIV. One challenge to this model is how to manage patients who are admitted to the hospital. For our patient, after she turned 23 years old, it became difficult to keep her on the pediatric ward with nurses and other providers uncomfortable with her chronologic age, which is not an uncommon finding.7,13

Continued on Page 12
Her care on the inpatient side was provided by the internal medicine service and adult oncology services during her final days while we continued to provide her HIV services.

The discussion of transition to adult care is a lengthy and complicated matter. Individualized approaches are surely more important than rigid programmatic plans given the continued cognitive development of young adults.3,4,14 For the patient above, I had offered to her transition of care to an adult provider clinic much closer to her home, but which was some distance from our hospital. She refused stating that she wanted to stay with our group, and was uncomfortable seeing someone new, a common issue in transitioning patients.

Keeping our patients engaged in care, improving medication adherence while providing the tools to succeed in the complex and changing healthcare system are of paramount importance.15 Transitional care clinics may provide a temporary solution for some of these problems, but they too have challenges that will need to be further addressed.

The most important component to transition of care is clearly the individual’s comfort. Further studies are needed to help us better enable adolescent and young adults to be comfortable moving into the adult HIV clinic setting. This mirrors other recommendations for chronic conditions managed by pediatric providers, e.g., Kawasaki Disease patients with coronary artery aneurysms.16 Developing a sense of comfort among the patient and providers clearly is an important component to successful transitions of care in this population.

References:
5. This material was accessed on 01/08/17 on the HIV Clinical Resource website (www.hivguidelines.org). The HIV Clinical Guidelines Program is a collaborative effort of the New York State Department of Health AIDS Institute and the Johns Hopkins University Division of Infectious Diseases. Copyright © Johns Hopkins University HIV Clinical Guidelines Program 2000-2016.
Continuing Challenges of Transition of Care ... Continued from Page 12


New AAP course: Challenging Cases: Dengue, Chikungunya, Zika Virus Infections” Now Available

The AAP released a new, free online course titled, “Challenging Cases: Dengue, Chikungunya, Zika Virus Infections”. Diseases such as dengue, chikungunya and the Zika virus that previously remained in remote areas of non-US countries, can now be transmitted across the globe in a matter of hours. It is crucial that pediatricians be prepared to diagnose and treat these diseases when they occur. The goal of the course is to increase the learner’s knowledge regarding the epidemiology, clinical manifestations, prevention and diagnosis of these three diseases. This course can be accessed here.

ID Pearls and Other Gems: Another Cat Bite and What is Aeromonas hydrophila?

Christopher J. Harrison, MD, FAAP, FPIDS, Professor of Pediatrics at the Children’s Mercy Hospital and UMKC, Kansas City, MO. Dr. Harrison will be happy to receive contributions from you and, if published, will be duly cited. Please send them to charrison@cmh.edu.

Day 1: A 5-year-old boy’s mother brings him for care. He was seen at the local urgent care yesterday morning for a “cat bite” that occurred when the boy went into the crawl space under the back porch. The encounter left a pair of puncture marks on his right forearm and multiple scratches on his hands and arms. The incident was not observed by an adult. The family could not find the cat. In the urgent care, the wounds were cleaned with peroxide and soap, with mupirocin applied after cleaning. He was given a DTaP and begun on amoxicillin-clavulanate. Overnight he developed a fever of 100.9°F and streaks running 4 cm up his arm. Mother says the streaks are less red now than last night, but the redness around the bite is worse. Today he is afebrile. There is a 5 X 8 cm area of warm, tender intense cellulitis surrounding the bite. There is what appears to be lymphangitis that is nontender and less erythematous than the cellulitis. He has no axillary adenopathy. The rest of his examination is normal. There is no active drainage or purulence.

You call Animal Control to report the bite. They state that they will try to find the cat. They also confirm that there have been no reported cases of cat rabies in your region for 20 years, so the risk of rabies seems low. The joint decision with the family is to hold off on rabies vaccine/immunoglobulin at present, but see the boy again tomorrow. Later that day, Animal Control reports that the “cat” appears to be an opossum. The family confirmed that the opossum was what bit him. The animal has been sacrificed for rabies testing. Results will be available in 24-48 hours. The Animal Control rabies expert reports that opossum rabies is also uncommon in your state and that it is OK to await rabies test results. However, you raise the issue that it is not assured that the trapped opossum from under the porch is actually...
the biter. The consensus however is that another two-days’-wait will not jeopardize the child. You also check the local hospital and are assured that they have rabies immune globulin and vaccine if they are needed.

**Day 2:** The next day, the streaks on the arm are nearly gone but the redness and swelling around the bites are somewhat larger and there is purulent drainage. You culture the drainage; Gram stain shows Gram-positive cocci and Gram-negative rods. He has had 5 doses of the antibiotic. Because of worsening of the main area of cellulitis and low-grade fever (100.5°F), you obtain a CBC: WBC is 12,300/mm³, with 66% neutrophils, 27% lymphocytes, and 7% monocytes. The Hgb is 13.1g/dL, platelet count is 294,000/mm3. CRP is 3.4 mg/L (normal up to 0.9). He does not appear too ill, so you decide not to hospitalize him, given that he has a good, vigilant and trustworthy family.

However, an on-line literature search reveals why amoxicillin-clavulanate may not be sufficient for an opossum bite. Opossums' oral flora may be more diverse than dogs or cats. This is likely due to their scavenging nature, with food sources ranging from garbage to animal feed to dead wildlife (mammals, fish or frogs). A 1990 report on the microbiology of opossum oral flora showed the usual suspects for animal bites (P. multocida and Eikenella corrodens) plus a range of streptococci, staphylococci, and Enterobacteriaceae. See Table 1. The authors of that report suggest the combination of trimethoprim-sulfamethoxazole (TMP-SMZ) and doxycycline as possible treatment. You interpret the resolving of the lymphangitis to be due to the amoxicillin-clavulanate’s effect on P. multocida and E. corrodens, which often cause lymphangitis after animal bites. But given the intensifying of the cellulitis, you add TMP-SMZ to the amoxicillin for more Gram-negative and MRSA coverage, pending culture results.

**Day 3:** The rabies test is positive, so vaccine and immune globulin are initiated. In addition, the cultures reveal *Aeromonas hydrophila*, *E. coli*, and MRSA, all susceptible to TMP-SMZ and resistant to amoxicillin-clavulanate. You choose not to change antibiotics because the cellulitis is much improved and he has been afebrile for 24 hours.

The child completes the post-exposure rabies treatment and antibiotic with no new issues and no sequelae are noted 3 months later.

**Take away:** So, while rabies is rare in opossums, it is not unheard of. And when a cat bite is really not a cat bite, but is an opossum bite, broader antibiotic coverage beyond the usual animal bite drug-of-choice (amoxicillin-clavulanate) seems appropriate. While amoxicillin-clavulanate covers most oral anaerobes plus dog/cat oral aerobes, it does not cover MRSA (cultured in this case) or include water-originating Gram-negative organisms such as *Aeromonas hydrophila*.

*A. hydrophila* is not common in pediatric practice. When most clinicians have the experience of culturing *A. hydrophila*, it is as a UTI pathogen or a cause of sometimes bloody diarrhea. The species name hydrophila means “water-loving” in Greek, which is appropriate for its usual source in traumatic soft tissue infections and even diarrhea. Treatment of *A. hydrophila* takes some thought. It is not usually susceptible to amoxicillin-clavulanate, macrolides or first generation cephalosporins, but is usually susceptible to TMP-SMZ, quinolones and third generation cephalosporins. *A. hydrophila* is also implicated in raccoon and python bites and some catfish spine injuries. However, *Edwardsiella tarda* is a more frequent offender with catfish spine injuries. A third-generation cephalosporin usually treats either of these two catfish-related, Gram-negative pathogens. Of note, *A. hydrophila* has also been a cause of swimming pool folliculitis, although Pseudomonas is more frequent in this diagnosis.

Most often there is no material suitable for culture after exotic/wild animal puncture bites with cellulitis. The antibiotic choice may be somewhat age-dependent. Clindamycin plus TMP-SMZ is an option (as it is for other animal bites in penicillin allergic patients). Doxycycline plus TMP-SMZ could be an option over the age of 8 years, but leaves some streptococci uncovered. If hospitalization is needed, meropenem plus vancomycin are an option.

Final thought: Be sure the “kitty” is really a kitty.

**References:**


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<tr>
<th>Gram-positive cocci</th>
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<td><em>Alpha streptococci</em>, (not group D)</td>
<td><em>Neisseria</em> spp.</td>
<td><em>Acinetobacter calcoaceticus</em> subsp. <em>lwoffii</em></td>
<td><em>Corynebacterium</em> spp</td>
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<td><em>Gamma streptococci</em></td>
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<td><em>Aeromonas hydrophila</em></td>
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<td><em>Citrobacter freundii</em></td>
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<td>Coagulase-negative <em>staphylococci</em></td>
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<td><em>Eikenella corrodens</em></td>
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<td><em>Pasteurella multocida</em></td>
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<td><em>Flavobacterium</em> spp.</td>
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<td><em>Pseudomonas</em> spp. (not <em>Pseudomonas aeruginosa</em>)</td>
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<td><em>Haemophilus</em> spp</td>
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*Figure 1. It’s not a kitty-cat. But maybe to a 5-year-old in the semi-dark, it looks close enough.*
ID Sessions at The AAP’s National Conference and Exhibition (NCE) September 16-19, 2017, Chicago, Illinois

The descriptions of the ID sessions sponsored by the SOID are on the Section website and the complete conference program can be accessed on the NCE website.

H3091- Section on Infectious Diseases Program

Date: 9/18/2017
Start/End Time: 1:00 PM-4:00 PM
Hours of CME: 2.75

Description: You Be the Judge: Why and How to Be Smart With Antibiotic Prescribing in Primary Care

This interactive, case-based program will engage pediatricians in a discussion about issues and solutions around practice-based antimicrobial stewardship. Clinicians and patients alike desire the most appropriate care. The dynamics of antimicrobial prescribing in practice, however, is complicated and affected by patient- and physician-based perceptions, expectations, and biases. This Program will describe the latest information on how excessive or otherwise inappropriate use of antibiotics affects individual patients and the community. Further, we will discuss real-life challenges and successes associated with establishing a variety of practice behaviors that actively considers stewardship. We will explore specific options and talking points for the clinician when a patient requests or is being considered for antibiotic therapy.

Agenda:

1:00 PM  Introductions
Moderator: Kenneth Zangwill, MD, FAAP

1:10 PM  The Prescription Antibiotic Burden and Review of Therapeutic Guidelines for Common Outpatient Infections
Jason Newland, MD, M.Ed., FAAP

1:35 PM  Impact of Inappropriate Antibiotic Use
Jason Newland, MD, M.Ed., FAAP

2:00 PM  Challenges to Implementing Stewardship in Primary Care
Julia Szymczak, PhD

2:45 PM  Communication Strategies for Managing Parent Expectations for Antibiotics
Rita Mangione-Smith, MD, MPH, FAAP

3:45 PM  Summary
Moderator: Kenneth Zangwill, MD, FAAP

4:00 PM  Adjourn
New Policy/Guidelines
Andrea Sperduto, MD FAAP, Cleveland Clinic Foundation

Besides the individual web sites listed below, links to the AAP ID policies, IDSA policies and the CDC ID Recommendations and Reports are all available at the SOID website: http://www2.aap.org/sections/infectdis/policy.cfm

I. MMWR
   1. 3 doses of Trumenba (MenB-FHbp) for persons at increased risk for meningococcal disease administered at 0, 1-2 and 6 months.
   2. 2 doses when given to healthy adolescents who are not at increased risk for meningococcal disease at 0 and 6 months.
C. Recommendations of the Advisory Committee on Immunization Practices for Use of Cholera Vaccine. MMWR May 12, 201766(18);482-485.
   1. In 2016, lyophilized CVD 103-HgR (Vaxchora), a single-dose, live attenuated oral cholera vaccine was approved by FDA.
   2. ACIP recommended use of June 2016 for adult travelers (aged 18-64 yrs.) to areas of active cholera transmission (see https://www.cdc.gov/travel/).

II. IDSA
   1. Recommendations are based on expert opinion.
   2. Specifically addressed are: signs and symptoms on physical exam, specific testing (laboratory and imaging), empiric antimicrobial treatment and infection prevention.

III. HIV Guidelines
Complete guidelines and information can be found at: http://aidsinfo.nih.gov/guidelines and are updated periodically. Some of the highlights are listed below.
A. Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents.
   2. TB diagnosis and treatment, Malaria treatment and Hepatitis C treatment.
B. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection.
   2. Updated recommendations for diagnostic testing of infants at higher risk of perinatal HIV transmission and those who have received multidrug antiretroviral prophylaxis.
   3. When to start initial combination therapy for antiretroviral treatment-naive children.
      a. Added age and weight limitations.
      b. Updated Preferred regimens based on recent FDA approvals, efficacy, ease of administration and acceptable toxicity.
         i. Added initial regimen of nevirapine plus 2 nucleoside reverse transcriptase inhibitors (NRTIs) for infants aged birth to <14 days of age.
         ii. Dolutegravir plus 2 NRTIs has been added as a Preferred initial regimen for children aged >6 to 12 yrs. (weight ≥30 kg).
         iii. Tenofovir alafenamide has been added as a Preferred NRTI for adolescents aged >12 yrs.
         iv. Efavirenz or lopinavir plus 2 NRTIs are now classified as Alternative rather than Preferred regimens for children ≥3 yrs. to <12 yrs. of age.
   4. Adherence to antiretroviral therapy monitoring for children living with HIV section added.
   5. Management for children receiving antiretroviral therapy.
      a. New regimens for children with sustained virologic suppression.
   6. Role of therapeutic drug monitoring.
      a. Use of patient pharmacogenetic profile for selection of dose and certain ARV drugs.
   7. Pediatric antiretroviral drug information.
      a. New pediatric data added on zidovudine, maraviroc and raltegravir.
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