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Chair’s Letter
Douglas Silverstein, MD, FAAP
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The SONp Executive Committee has been busy planning for future activities and initiatives. It intermittently develops a new strategic plan to guide future directions and establish goals. These are based on a review of the section’s completed activities and on our assessment of how we can contribute to the continued growth and education of our section members and all pediatricians. These strategic objectives are the product of discussions among the section members, our section liaison, and other academy experts.

The general categories that the section considers in our 2015-2016 strategic objectives include education, research, member value, workforce issues, and advocacy. There is occasional overlap for some objectives among these four categories. Each objective includes measure(s) that define(s) how the objective is to be achieved.

A core principle of the SONp is to enhance the educational experience and promote the accrual of knowledge for pediatric nephrologists and general pediatricians. We strive to achieve this by using applicable language in our educational documents and identifying the knowledge gaps for each audience.

Among the educational measures we seek to achieve are:
- Developing an online PediaLink course for general pediatricians regarding nephrology topics
- Exploring the development of joint NCE programs with other sections to expand the reach of pediatric nephrology educational programming
- Developing a resource for nephrologists regarding transition programs for children with kidney disease
- Writing AAP Healthychildren.org articles for parents of children with kidney disease
- Continuing to contribute to PREP Nephrology for MOC Part 2
- Establishing a nephrology visiting professor program (to expand nephrology education at local hospitals and medical schools)

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Chair's Letter

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• Developing policies to support primary care pediatricians in practice (e.g., providing technical reports, submission of resolutions to the annual leadership forum, and contributing to the development of nephrology-related guidelines for topics such as fluid management and blood pressure monitoring)

The SONp is continually exploring mechanisms to enhance member value. We are cognizant and respectful that alternative resources are available for specialists and general pediatricians; therefore, we have debated in which areas we can provide a unique value and service to our audience. Our efforts will involve the following:

• Expanding Part 4 MOC programs for pediatric nephrologists by leveraging the AAP’s unique and strong association with the American Board of Pediatrics (ABP). The AAP SONp aims to work with our section members and the ABP to develop or modify quality programs for part 4.

• Participating in the AAP Subspecialty Summit and Annual Leadership Forum (ALF). The section chair attended and contributed to a Subspecialty Summit held in March, 2015 with the aim to optimize the AAP experience for subspecialists. The ALF meetings help guide the AAP on future initiatives. Our recent resolutions have been approved by the attendees at the ALF.

• Communicating to our section members via section newsletter and e-updates.

• Involving section members, including training fellows, in the review of policies and other documents, developing guidance documents, making presentations at national meetings, and writing manuscripts.

Similar to other subspecialties, pediatric nephrology continues to face workforce challenges in recruiting and retaining nephrologists. The reasons for the difficulty in broadening our workforce are many, including financial constraints, commitment to a high complexity of patient care, and attractiveness of alternative work arrangements (e.g., shift work). These issues are explored in an article, “The US Pediatric Nephrology Workforce: A Report Commissioned by the American Academy of Pediatrics” published in the American Journal of Kidney Disease and was based on the results of an AAP-ASPN workforce survey completed in 2013. Our efforts to address the workforce challenges in pediatric nephrology will involve the following:

• Developing resources for residents regarding pediatric nephrology.

• Sharing information regarding summer camp and community outreach opportunities with young physicians as a way to enrich their training experience.

• Establishing a connection to the AAP Section on Medical Students, Residents and Training Fellows (SOMSRT) to promote pediatric nephrology to residents.

• Conducting a follow-up survey of residents regarding their pediatric nephrology training during residency and factors that impacted their decision about pursuing pediatric nephrology subspecialty training in the future.

Finally, the section will continue to work with the AAP to support advocacy for our section members and patients. Our relationship with the AAP provides a unique and strong opportunity to influence advocacy issues that may not be achievable by other societies. Indeed, the AAP represents about 64,000 pediatricians and their patients. Advocacy programs will include:

• Supporting improved research and clinical trials via AAP programs including the Pediatric Research in Office Settings (PROS) and quality improvement programs.

• Serving as a liaison between pediatric nephrologists and the AAP, providing a conduit for section members to convey their concerns and ideas about practice.

• Continuing to monitor access to subspecialty care and broadening loan repayment to focus on underserved subspecialties such as pediatric nephrology.

In summary, our strategic plan is bold and aggressive, but one that we feel is achievable and, most important, essential. The section occupies a unique space in the nephrology community and intends to broaden its reach with the goal of providing greater benefit to our section members.

Special Announcements from the Chair

The AAP and the Section on Nephrology (SONp) is able to accomplish so much due to the time given and the commitment made by our members. On that note, I am happy to announce that there is a new MOC part 4 activity available that
includes education and quality improvement tracks for the pediatric nephrologist and general pediatrician regarding
the management of pediatric hypertension. See page 7 in the newsletter regarding how to access the EQIPP module.
With that I would like to acknowledge the hard work of the following section members in the development of the EQIPP
module:

- Carissa Baker-Smith, MD, FAAP (Section on Cardiology and Cardiac Surgery)
- Donald Batisky, MD, FAAP
- Daniel Feig, MD, FAAP
- Joseph Flynn, MD, FAAP
- David Kershaw, MD, FAAP
- Kevin Meyers, MD, FAAP

Also, I would like to take this opportunity to thank Dr. Nicole Christin for serving as the SONp's first Training Fellow
Liaison over these past two years and for her valuable contributions and service to the SONp. The SONp is pleased to
welcome Dr. Lyndsay Harshman as our incoming training fellow liaison. Dr. Harshman is in her second year of fellowship
at the University of Iowa and is participating in the American Board of Pediatrics Integrative Research Training Pathway.

Finally, I would like to take this time to acknowledge the recent passing of esteemed SONp member, Dr. Russell Chesney,
and recognize his significant contributions to pediatrics and the field of pediatric nephrology. In recognition of his
many career achievements in leadership, advocacy, research and patient care, Dr. Chesney received the AAP Section on
Nephrology Henry L. Barnett Award in 2004.

AAP Mentorship Program

Mentorship is an important tool for professional development and has been linked to greater
productivity, career advancement, and professional satisfaction. The AAP recognizes that mentorship is
critical in helping nurture future leaders and a key opportunity to engage existing members and leaders.
The AAP Mentorship Program seeks to establish mentoring relationships between trainees/early career
physicians and practicing AAP member physicians. A primary goal is to promote career and leadership
development. Mentors will have opportunities to further develop leadership skills and learn about emerging trends from
the next generation of their peers. Mentees will gain a trusted advisor and learn methods to enhance career advancement.
And all parties will form professional relationships and share advocacy, professional, and research interests.

Becoming involved is very easy. The only requirement to participate is to be a national AAP member in good standing.
Participants need only sign-up and complete an online mentor/mentee profile form (you can sign up to be both a mentor
and mentee if you so choose). The profile form collects information on education/training, subspecialty interests,
practice/professional/clinical interests, and the amount of time the participant is willing to commit. Mentors/mentee
pairs will have the ability to meet traditionally in person if they choose a local match or use one of several online tools to
meet virtually.

The program is set-up for both “traditional”, long-term relationships as well as short-term “flash” mentoring. The
flash mentoring component allows for mentees to contact mentors for quick questions, set up 1-2 meetings, as well as
participate in online topical forums and Q&A forums. Therefore, the time commitment and expectations can be tailored
to fit each mentor/mentee pairs’ needs. [Please note: Administrators reserve the right to deactivate participants after 6
months of inactivity.]

Visit www.aapmentorship.chronus.com and sign up to be a mentor and/or mentee today! AAP login and password
required. Any questions can be directed to: Julie Raymond jraymond@aap.org or Barb Miller bmiller@aap.org

Chair's Letter Continued from Page 2
I am amazed at how fast these last 2 years have flown by and I have truly enjoyed all the countless experiences and opportunities my position on the SONp Executive Committee as the Fellow Liaison has provided me. Serving in this position has enriched my fellowship experience, which is also sadly coming to an end. I feel like this would be a good time to share what I have gained from my journey through fellowship and on the Executive Committee so that it may be helpful to others who will be starting or are in the midst of their fellowship.

**Try something new:**
I did this when the SONp sponsored my attendance at the Advocacy Training program through the AAP Department of Federal Affairs. This opportunity allowed me to learn more about how we as physicians can advocate for our patients at the State and Federal Level. I was even able to sit down with Congress staff members and share with them my perspectives about caring for children with a chronic medical condition.

Every institution and university library offers extensive programs and courses, usually available to residents/fellows at a reduced rate, which are beneficial to any physician working in an academic setting. Learn Medical Spanish, take a statistics course, or master End Note. I was overwhelmed at first and eager to sign up for everything. But, be cautious and realistic. Do not try to tackle too much! Every year, sit down and set specific goals you would like to accomplish as a researcher, physician and educator. Try to find courses that will address your goals, then, reflect and re-evaluate mid-year on your progress.

**Conferences/Meetings:**
As the SONp Fellow Liaison, I represented the Section at a two day Council of Pediatric Subspecialties (CoPS) Meeting where I met with leaders from all of the pediatric subspecialties and those from major academic organizations. I participated in discussions about Board exam costs, fellowship start dates, maintenance of certification requirements, and the evaluation of house staff through core competencies and milestones.

As you go through your fellowship, you will find that there are so many conference/meeting options to choose from and each one offers something unique. The first task is to decide whether you want to attend a conference focusing on a specific aspect of the field. I recommend reviewing the proposed speakers and talks planned for the event in advance to see if what the conference offers meets your needs. Take advantage and try to attend at least one conference a year. Most conferences have reduced rates for training fellows and/or award travel grants. I found it a good idea to take a few vacation days around conferences to enjoy a new city (sometimes the location was a deciding factor into which conferences I attended!).

**The Job Hunt:**
For many finding your first job after fellowship is the first time ERAS has not done the work. What I have learned throughout this process is to start early and be patient. Make sure your CV is up to date and that you have a cover letter. Try to find faculty members at your institution to review these documents in advance as well and listen to their advice - they review many throughout the year and can offer invaluable insight. It is also important to know that your “dream job” may not be waiting for you right out of fellowship. Every position available will offer something unique and will allow you to grow and develop. But it is important for you to know your “must haves” and “must have nots” and to research every open position before applying so that you do not waste your own time nor a programs'.

**Enjoy the Ride!**
Update On the AAP Pediatric Clinical Trials Stakeholder Forum

On November 4-5, 2014, the American Academy of Pediatrics (AAP) convened key stakeholders to discuss the feasibility of accelerating medical advances for children by creating an independent, global Pediatric Clinical Trials Network. The participants’ task was to address the challenges currently posed by the U.S. and global clinical trial systems with respect to testing and disseminating drugs and devices for pediatric patients — and thereby to improve the safety and efficacy of pediatric drugs, biological products, and medical devices.

The Forum brought together an unprecedented number of leaders with diverse backgrounds and interests, including clinicians, academicians, regulators, patient advocates, parents, AAP leadership, and representatives from the pharmaceutical industry and other focused disease Networks.

Among the participants, there was wide agreement about the need for:

• An improved, innovative approach to planning pediatric studies and the commensurate pediatric clinical trial infrastructure to perform those studies.
• Timely development of age-appropriate formulations, evaluative tools, and biomarkers for the pediatric population's developmental continuum.
• Reduction of administrative barriers that hamper safe and efficacious products being assessed through clinical trials and accessed by the patients who need them.
• More robust, publicly available data that demonstrate the safety and efficacy of drugs and devices used in children, and that are communicated in a timely manner.
• Shorter time frames between adult and pediatric labeling.
• More integrative work across a variety of stakeholders.

The Forum offered a unique opportunity for stakeholders to address these needs by sharing ideas and mapping a vision to enable change through the formation of a global Pediatric Clinical Trials Network. The Network is anticipated to improve the current landscape by providing a central infrastructure spanning all pediatric sub-specialties, and fostering access to dedicated staff providing clinical research sites with scientific, medical, and operational support. In turn, a Network would facilitate the development and availability of innovative, high-quality therapies to help extend and enhance the lives of neonates, infants, children, adolescents, and young adults.

The Forum participants expressed a strong interest in the formation of such a network and conveyed a clear sense of urgency to proceed. Despite much progress — with over 500 products now having been studied in children — drugs and devices are still often coming to market without adequate pediatric indications, particularly in the areas of neonatology and rare diseases. This has negative effects on children and their families. It behooves the community to support this effort and strive together to create and implement a Network.

The Forum closed with the development of a consensus statement about the participants’ shared vision for a Network and their commitment to implementing such an entity in the near future.

Consensus Statement

The attendees of the Pediatric Clinical Trials Stakeholder Forum resolved to establish a Global Pediatric Clinical Trials Network and are committed to engage in the work to create and sustain it.

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Update On the AAP Pediatric Clinical Trials Stakeholder Forum Continued from Page 5

World experts in pediatric pharmacology and pediatric clinical trials assembled on November 4 and 5, 2014 for the AAP Pediatric Clinical Trials Stakeholders' Forum

Funding for this Forum and meeting proceedings was made possible by an unrestricted contribution from The Pharmaceutical Research and Manufacturers of America (PhRMA)

Summer Sale: Avoid higher rates for PREP – Save Today!

As an AAP subspecialty section member, you're eligible for special rates for annual PREP Self-Assessment subscriptions within your specialty. Whether you're preparing for an exam, looking for the latest clinical updates, or fulfilling MOC requirements, PREP Self-Assessments provide an easy-to-use comprehensive review from topic experts. This summer, PREP subscription rates are scheduled to increase. However, for a limited time—when you purchase a 2015 PREP subscription on ShopAAP, you can take an extra $50 off* an additional 2013 or 2014 subscription by using promo code PREPMEM50 at checkout. Visit http://shop.aap.org/prepme50 to get started.

Don't wait—get your PREP today! This special offer from ShopAAP ends June 30th.*

*Offer expires 6/30/2015. Offer is not valid for existing subscriptions and cannot be combined with any other offer. All pricing is subject to change without notice. Need assistance? Contact AAP Customer Service at csc@aap.org.
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- Enhance communication and the

EQIPP courses help satisfy MOC Part 4 requirements!

More available topics: asthma, diabetes, GER/GERD, growth surveillance & linear growth failure, immunizations, medical home, newborn screening, tobacco use & secondhand smoke elimination, and oral health

eqipp.org

This course has been developed by the American Academy of Pediatrics (AAP) with support from the AAP Friends of Children Fund. The work was developed in collaboration with American Society of Pediatric Nephrology (ASPN) and International Pediatric Hypertension Association (IPHA).
Outcomes after chronic dialysis initiation in the neonatal period

Vikas R. Dharnidharka, MD, MPH
Division of Pediatric Nephrology, Washington University School of Medicine, St. Louis MO, USA

Case presentation:

A 26-year-old woman in her first pregnancy presents to your clinic at 26 weeks gestation with twins. A prenatal ultrasound done yesterday has revealed that the male twin B has markedly enlarged and highly echogenic kidneys. Twin girl A has normal sized and appearing kidneys and the amniotic fluid volume is normal. The parents ask you if chronic dialysis is feasible in babies. They also ask what the boy's future might be like if he needs chronic dialysis shortly after birth.

Introduction:

The pediatric nephrologist is not infrequently faced with a clinical situation involving congenital renal anomalies with chronic renal failure, either as an antenatal consult or in the newborn nursery/ICU. In such situations, one of the common questions asked by the families or the treating physicians is whether initiation of chronic dialysis this early in life is worth pursuing.

This question involves several aspects, including:

a) Can we dialyze? i.e.:
   i) how feasible is chronic dialysis in this age group and by the baby's size?
   ii) what are the long-term outcomes of chronic dialysis started this early?

b) Another related, but different question is the value of providing dialysis, which then reaches into ethical issues and associated comorbidities.

The purpose of this article is to discuss aspects of question (a), especially with regard to the long-term outcomes reported after chronic dialysis is initiated in the neonatal period. The ethical issues are beyond the scope of this article and are discussed extensively elsewhere 1.

How feasible is chronic dialysis in the neonatal period?

Chronic peritoneal dialysis has been possible in neonates for several decades. Fortunately, technical advances in dialysis catheters and equipment have improved the capabilities of peritoneal dialysis and also allowed us to perform chronic hemodialysis in some neonates.

Peritoneal dialysis catheters come in various lengths and shapes. In the USA, the lengths range from 31 cm and 38.9 cm (pediatric, infant) to maximum 47 cm (adult). The diameter tends to be constant at pediatric size and above (internal diameter 3.5 mm and external diameter 5.3 mm. Only the infant catheters have a smaller diameter (2.5 mm internal and 3.7 mm external). Infant catheters can have either a flex “swan” neck shape or a curl/coiled shape and may come with either 1 or 2 cuffs. The pediatric automated cycler machines now in use can program fill volumes as low as 60 mL. Below the 60 mL volume, manual setups can be utilized. Therefore, for all practical purposes, peritoneal dialysis is possible in most children, including neonates. Peritoneal dialysis is even possible in some pre-term babies. The clinical limitations and contraindications to performing peritoneal dialysis in the neonatal period are similar to those for older infants and children.

Chronic hemodialysis machines and circuits have also seen technical advances. Hemodialysis can be performed via catheters as small as 5 French, though the larger 7-9 French diameter is preferred. The infant lines that connect the patient to the machine have extracorporeal volumes of just 19 mL. The smallest hemodialysis cartridges have a volume of 18-28 mL. Blood flow per minute can be as low as 20 mL/minute. Thus, chronic hemodialysis is possible in neonates where the centers have the appropriate equipment available.

Can renal diagnosis and outcomes be predicted in utero?

Two separate studies, both from France, have investigated this question. Tsatsaris et. al. studied 43 fetuses with in utero cystic and hyperechoic renal abnormalities who had follow-up of 34 to 132 months2. Despite a negative family history in 34

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of the 43, polycystic kidney disease was the most frequent diagnosis (recessive type in 44%, dominant type in 12%), with a variety of other conditions comprising the remainder. In the overall group, the combination of very large kidney length (> 4 standard deviations above the mean for gestational age) and presence of oligohydramnios resulted in 10 terminations of pregnancy, 4 neonatal deaths, 0 survivors, 0 symptom-free survivors. Conversely, normal or increased amniotic fluid volume, in conjunction with kidney length < 4 standard deviations above the mean, resulted in 3 terminations, 0 neonatal deaths, and 14 survivors, of whom 9 of these 14 were symptom-free. Cases that fell in between these two extremes had less clear-cut outcomes. Chaumoitre et. al. reviewed 93 fetuses with hyperechoic cystic kidneys3. Again, the polycystic kidney diseases were most common, followed by Bardet-Biedl syndrome. This study found that cyst characteristics (size, number) were not helpful in predicting diagnosis while associated malformations were. Together, these studies suggest that both exact diagnosis and subsequent renal outcomes are predictable with reasonable but not perfect accuracy.

Outcomes after chronic dialysis is initiated in the neonatal period:

A recent case report showed that serial amnio-infusions may allow for better pulmonary development in utero where a major renal anomaly exists4. If such a therapy is to become widespread, the key question is whether long-term chronic dialysis from the neonatal period onwards is feasible and associated with good outcomes. Three recent multi-center studies have investigated the longer-term outcomes (patient survival, success in receiving a kidney transplant) after chronic dialysis was initiated in the neonatal period. Each of these studies used a multicenter nephrology-focused database. Therefore, the results of each of these studies should be interpreted with the caveat that a selection bias likely exists. Children who were likely to die very early may never get entered into such databases. The denominator of all cases is therefore unknown.

Carey et. al. examined data from the North American Pediatric Renal Trials and Collaborative Studies (NAPRTCS) database, over a period from 1992 to 20055. This study examined data on 505 children between 1-24 months age or 193 babies < 1 month old at dialysis initiation. This study found that a) 98% of neonates were started on peritoneal dialysis; b) neonates had a low 11% rate of death, with improved survival in the more recent 1999-2005 cohort versus 1992-1999 cohort; c) 47% transitioned to a kidney transplant, albeit at later time points than children initiated on chronic dialysis between 1-24 months. Causes of death were not mentioned. Carey et. al. have presented an update of the same data, now including results until 2012, at a recent conference.

Alexander et. al.6 looked at data across all Canadian centers on 87 children who initiated chronic dialysis under the age of 2 years, which included 31 babies who initiated prior to 3 months age. Their study showed a high initial death rate of 37%, almost all in the first 6 months, but excellent survival thereafter, such that 46% received a kidney transplant. Like Carey et. al., this group found a lower mortality in a more recent cohort and a slight delay in receiving a transplant in the neonates versus older infants. Causes of death were varied but infections predominated.

More recently, van Stralen et. al. used multiple international databases to assess outcomes across the world7. This study included 264 babies under 1 month of age, of whom 92% initiated chronic peritoneal dialysis and the remainder initiated chronic hemodialysis. At 5 years of follow up, the death rate was 20%, while ~50% received a kidney transplant. Infections accounted for 35% of the deaths. Neurological co-morbidity increased the death risk five-fold.

Together, these studies suggest a surprisingly good rate of patient survival and a high rate of kidney transplantation. Note that each of these studies is limited by a selection bias wherein those more likely to survive were more likely to be entered into these voluntary databases. The full denominator of all babies who initiated peritoneal dialysis in the neonatal period is therefore not known. Nevertheless, these studies suggest that we can effectively maintain many of these babies on dialysis for a long time and get them to a kidney transplant. A “gloom and doom” outlook may thus be unwarranted. What these studies were unable to assess is how the comorbid conditions may have impacted the decision to dialyze or not. This question will require a multicenter analysis of detailed databases with both neonatal and renal data.

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Besides these multicenter reports, two other reports provide single center results. Rheault et. al. evaluated the long-term outcomes at their center in babies who started peritoneal dialysis prior to 28 days. In their cohort of 23 children, the 5-year survival was 48%. Twelve received a kidney transplant, with an excellent 5-year graft survival of 83%. In fact, in national databases, infants have the best 10 year graft survival of ~80% among all recipient age groups. Still, these children can expect to receive multiple kidney transplants over their lifetime. The lowest size/weight that an infant can receive a kidney transplant varies by center, but is within a 6.5 to 10 kg weight or 65-75 cm length range.

Mekahli et. al. reported long-term outcomes on 101 children with a GFR < 20 ml/min/1.73 m² at 0.3 years of age. These children did not have to be on chronic dialysis. Five year survival was 77% and 10 year survival was 75%. Notably, 66% were tube fed for 1.7 yr (range 0.1 to 6.9 yr), 37% had a gastrostomy, and 13% had a Nissen fundoplication. Many of these children therefore need additional nutrition which they are unable to take by mouth. Some require high caloric concentration formula above the standard 20kcal/30 ml formula, made possible by addition of substances like protein powder, starch or medium chain triglyceride oil.

Summary

Current data suggest that we can partly predict which fetuses will need chronic dialysis as neonates. The current data also suggest that good renal outcomes are achievable. The decision to dialyze or not may then depend on number, extent and severity of associated co-morbidities.

Figure 1. Patient survival after chronic dialysis was initiated in the neonatal period (0-3 months age). Survival data are estimated in the figure by the author from the Kaplan-Meier survival curves displayed in the original publications. The data shown from Carey et. al. represent only their more recent 1999-2005 cohort of 0-1 month age initiation.

Mekahli et. al. reported long-term outcomes on 101 children with a GFR < 20 ml/min/1.73 m² at 0.3 years of age. These children did not have to be on chronic dialysis. Five year survival was 77% and 10 year survival was 75%. Notably, 66% were tube fed for 1.7 yr (range 0.1 to 6.9 yr), 37% had a gastrostomy, and 13% had a Nissen fundoplication. Many of these children therefore need additional nutrition which they are unable to take by mouth. Some require high caloric concentration formula above the standard 20kcal/30 ml formula, made possible by addition of substances like protein powder, starch or medium chain triglyceride oil.

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References:

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The Business of Pediatric Nephrology:
ICD-10-CM is Coming October 1 - Are you Preparing?

The AAP has been working hard to develop tools and resources to help you and your practice prepare for the transition.

➢ Several ICD-10-CM publications have been developed and are available in print and as eBooks including
  • Pediatric ICD-10-CM: A Manual for Provider-Based Coding
  • Pediatric Code Crosswalk: ICD-9-CM to ICD-10-CM
  • Principles of Pediatric ICD-10-CM Coding
➢ AAP Pediatric Coding Newsletter—the AAP’s premier coding advisory featuring a monthly column on ICD-10-CM with coding tips and guidelines for successful migration.
➢ Two unique ICD-10-CM webinars (Part 1 and Part 2) were developed and are available for viewing.

For more information on these exclusive AAP coding resources, visit for pediatric-specific guidance for ICD-10-CM success! http://shop.aap.org/products/Coding/

A website was created for all things ICD-10-CM www.aap.org/coding/ICD10. This includes a pediatric ICD-10-CM Superbill and an FAQ. And as always, the AAP’s Coding Hotline is here to answer all your coding questions related to the ICD-10-CM transition.

aapcodinghotline@aap.org

Please do not delay any longer in your preparation for the transition!!

What questions do you have as pediatric nephrologists regarding the transition to ICD-10? Please send them to Suzanne Kirkwood at skirkwood@aap.org and we will answer them in the next edition of the newsletter.
Welcome to our New SONp Members

If you know of others who might be interested in joining the Academy and the Section, please have them call 1-800-433-9016 ext. 5885 or go to www.aap.org. The link entitled Member Benefits will take them to an application. Current Academy members may join the Section by accessing the online application (member ID and login required) at: http://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Pages/Council-Section-Membership.aspx

AAP Fellows

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<td>Jean Bender, MD, FAAP</td>
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INTERNATIONAL MEMBERS

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<td>Yohei Ikezumi, MD</td>
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<td>Deepti Narla, MD, FAAP</td>
<td>Pittsburgh, PA</td>
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A special welcome to training fellows who were added to the Section.
(As of July 1, 2012, Section dues for pediatric nephrology training fellows were eliminated.)
Call for Nominations
2016 Henry L. Barnett Award

The American Academy of Pediatrics Section on Nephrology is now accepting nominations for the 2016 Henry L. Barnett Award.

Background
This award was established in 1990 as the Kidney Award, but the name was changed in 1994 to the Henry L. Barnett Award to recognize the contributions of Dr. Barnett to the field of pediatric nephrology.

Qualifications and Nominations Procedure
The AAP Section on Nephrology recognizes one individual yearly for lifetime achievement in the field of pediatric nephrology. Any pediatric nephrologist can be nominated for this award. This individual should meet one or more of the following qualifications:

➢ Dedication to teaching nephrology
➢ Contributions to advocacy for children
➢ Distinguished service to the field of pediatric nephrology

Current members of the Section on Nephrology Executive Committee may not be nominated.

Previous nominations will automatically be considered for 3 consecutive years. Nominations must be in writing and should clearly state the basis for the recommendation, including the nominee's qualifications for the award and examples of relevant achievements. Please submit the Nomination Form, Nomination Letter, along with a copy of the nominee's CV either electronically (skirkwood@aap.org) via fax (847/434-8000 Attn: Suzanne Kirkwood) or to the address below. Nominations are limited to one per nominator. Please note: previous nominations can be resubmitted with a brief letter indicating nominator and the name of nominee. The deadline for nominations is September 30, 2015.

American Academy of Pediatrics, Section on Nephrology
2012 Henry L. Barnett Award
141 Northwest Point Blvd., Elk Grove Village, IL 60007
Attn: Suzanne Kirkwood

Previous Henry L. Barnett Award Recipients

<table>
<thead>
<tr>
<th>Year</th>
<th>Nominee</th>
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<th>Nominee</th>
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</thead>
<tbody>
<tr>
<td>2015</td>
<td>Bradley Warady, MD, FAAP</td>
<td>2003</td>
<td>Richard N. Fine, MD, FAAP</td>
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<td>2014</td>
<td>Denis Geary, MD</td>
<td>2002</td>
<td>Alan B. Gruskin, MD</td>
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<td>2013</td>
<td>Robert Chevalier, MD, FAAP</td>
<td>2000</td>
<td>Shane Roy III, MD</td>
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<td>2012</td>
<td>Sandra Watkins, MD</td>
<td>1999</td>
<td>John Lewy, MD</td>
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<td>2011</td>
<td>James Chan, MD, FAAP</td>
<td>1998</td>
<td>Malcom Holiday, MD</td>
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<td>2010</td>
<td>Aaron Friedman, MD, FAAP</td>
<td>1997</td>
<td>Jay Bernstein, MD</td>
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<td>2009</td>
<td>Julie Ingelfinger, MD</td>
<td>1995</td>
<td>Clarke D. West, MD</td>
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<td>2008</td>
<td>Ellis D. Avner, MD</td>
<td>1994</td>
<td>Wallace McCrory, MD</td>
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<td>1993</td>
<td>Robert L. Vernier, MD</td>
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<td></td>
<td></td>
<td>1992</td>
<td>Henry L. Barnett, MD and Ira Griefer, MD</td>
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<td></td>
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<td>1991</td>
<td>Jack Metcoff</td>
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<tr>
<td>2004</td>
<td>Russell Chesney, MD, FAAP</td>
<td>1990</td>
<td>Section on Nephrology establishes “The Kidney Award”</td>
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</table>
Upcoming Meetings

Pediatric Educational Excellence Across the Continuum (PEEAC) Conference
September 18-19, 2015
Atlanta, Georgia

AAP National Conference & Exhibition
October 24-27, 2015
Washington, D.C.

Kidney Week 2015
November 3 – 8, 2015
San Diego, CA

National Kidney Foundation - 2016 Clinical Meeting
April 27 – May 1, 2016
Boston, MA

2016 Pediatric Academy Societies
April 30 – May 3, 2016
Baltimore, MD

European Renal Association-European Dialysis and Transplant Association – 53rd Congress
May 21-24, 2016
Vienna, Austria

48th Annual Scientific Meeting of the European Society of Pediatric Nephrology
September 3 - 5, 2015
Brussels, Belgium
The Section on Nephrology
Executive Committee

Chairperson:
Douglas Silverstein, MD, FAAP

Executive Committee:
Manju Chandra, MD, FAAP
Nicole Christin, MD, FAAP
Vikas Dharnidharka, MD, FAAP
Frederick Kaskel, MD, PhD, FAAP
Teri Jo Mauch, MD, PhD, FAAP
William Primack, MD, FAAP

Immediate Past-Chair:
Larry Greenbaum, MD, PhD

Nominations Subcommittee:
John Foreman, MD, FAAP
Tej Mattoo, MD, FAAP

Barnett Award Subcommittee
Steven Alexander, MD, FAAP
Eileen Ellis, MD, FAAP
Gaurav Kapur, MD, FAAP

Staff
Suzanne Kirkwood, MS
Manager, Section on Nephrology

Mark A. Krajecki
Journal Production Specialist

For Upcoming Newsletters . . .
We welcome your input and encourage you to submit ideas or information by email to Doug Silverstein, MD at dsilverstein2001@yahoo.com or Suzanne Kirkwood at skirkwood@aap.org for future issues of the newsletter.