Increased Support for Medical Student Members of the AAP: Report from the Annual Leadership Forum (ALF)

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Each year leaders from various AAP Chapters, Sections, Committees, and Councils gather in the Chicago area for the AAP Annual Leadership Forum (ALF). The purpose of the ALF is to draw upon multiple areas of expertise within the Academy to advise and make recommendations to the Board of Directors (AAP Leadership). Through a demanding resolution process, attendees discuss and vote on resolutions related to the concerns and issues facing children and pediatricians throughout the country.

This year’s ALF was a particularly relevant and successful meeting for medical students and the Section on Medical Students, Residents, and Fellowship Trainees (SOMSRFT). Not only did we make history by having a medical student participate in the ALF for the first time, we also helped pass a resolution that has the potential to directly impact medical students by enhancing their membership status within the AAP.

The resolution was brought forth by Dr. Robert Jacobson, a pediatrician from the Mayo Clinic and member of (Continued)

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District VI (AAP District Map). Dr. Jacobson’s resolution, which was supported by SOMSRFT at the ALF, addressed concerns about the cost of AAP membership for medical students, their status as affiliate members (as opposed to national members), and the current benefit package provided to medical students. Not only did the resolution pass with resounding support, it also was voted by the ALF attendees into the “top 10” list (#9), which establishes it as one of the key AAP issues in the coming year for the Executive Board of the AAP to consider. The AAP News story announcing the top 10 resolutions can be found here: AAP News Top 10.

Although this resolution and its widespread support does not guarantee immediate changes to the cost, benefits, and medical student membership category, it certainly highlights the support for medical student members throughout the AAP. It also further asserts that AAP members recognize the diverse and valuable contributions medical students make to improve the health of children.

SOMSRFT and the Medical Student Subcommittee members will continue to work hard to ensure that medical student AAP members recognize their full potential as future pediatricians and receive the support, leadership opportunities, and benefits they need to jumpstart their careers. We will continue to update you as positive changes occur in regards to the medical student membership resolution, and hope that if you have any questions or concerns you will contact your Medical Student Subcommittee District Representative. Enjoy the summer and we look forward to a new and exciting year for medical students and the AAP!

Pediatric Mobile Clinic: Bringing the Clinic to Where it is Needed Most

Melissa Stone, M3; University of Miami Miller School of Medicine

In 1992, Hurricane Andrew invaded South Florida. Winds at 175 miles per hour struck down palm trees and roof tops, leaving an estimated 175,000 people homeless and 1.4 million without electricity. Transportation was limited and often dangerous with massive flooding and live power lines blown to the ground. Andrew severely damaged the healthcare infrastructure at a time when South Florida residents needed it most. In the wake of Andrew, the University of Miami Pediatric Mobile Clinic (PMC) was established.

The size of a large school bus, the PMC is a healthcare clinic on wheels. Fully equipped with three patient exam rooms, a procedure room, medications, vaccines, and a team of healthcare providers, the PMC is able to bring the clinic to children in need.

While there are many government services to provide healthcare for children, not all children have access to these services. For example, when a family immigrates to the United States and it often takes some time for them to complete the Medicaid paperwork and to be approved for services. Other times, the family has illegally immigrated and is afraid to seek care for fear of legal repercussions. And sometimes, the family has insurance but lacks adequate transportation and if the only in-network providers are a long distance away parents cannot afford to miss an entire day of work to commute to one doctor’s appointment. Regardless of the particular need of the family, the PMC will always put the health of the child first and will never charge for any healthcare services.

With a catchment area spanning a 50-mile radius, the PMC travels throughout South Florida to the most underserved areas in Miami-Dade County and in each area, and is prepared to care for the unique issues faced by that population. For instance, Little Haiti is a low-income area of Miami mostly composed of Haitian immigrants, (Continued)
many of whom do not speak English and have a limited understanding of the American healthcare system. After the 2010 earthquake in Port-au-Prince, Haiti, thousands of child refugees came to Miami, many to Little Haiti, and most in dire need of physical and mental health services. Advertising through local schools and churches, the PMC recruits patients to come to the Little Haiti Cultural Center. There, the PMC works with the center’s staff to provide healthcare for the children of Little Haiti. Through this joint effort, the PMC attenuates the cultural and language barriers to healthcare for the children living in Little Haiti.

The PMC also travels to Homestead, a largely agricultural city bordering the Everglades. Many of the children here are the sons and daughters of undocumented migrant workers who immigrated to Miami from Central and South America, and now spend their days working the fields. Growing up in poverty and making the journey to the United States, many of these children have suffered from traumatic experiences in their short lives. Thus, the PMC does more for these children than check-ups and immunizations. The PMC has an onsite psychologist, providing counseling to children and their families. Additionally, when a child needs a specialist such as a dermatologist, cardiologist, or nutritionist, the PMC utilizes telemedicine to bring the specialized University of Miami healthcare provider to the patient.

While the PMC fills a critical gap in our healthcare system, it also helps families properly utilize other services in the system. A social worker travels with the PMC and helps families obtain health insurance for their children. Additionally, a vision van, developed by the Bruce Heiken Children’s Vision Program, and a dental van funded through the Miami-Dade County Health Department travel with the PMC several times each month, providing optometric and dental care conveniently and free of charge. The PMC is also prepared to handle children with complex medical needs, which make up 13% of its patient base, and has been proven to contribute to the reduction of emergency room visits for these patients, thus reducing healthcare costs for the community.

With strong institutional support through the University of Miami Miller School of Medicine, the PMC is an integral part of the medical school and residency program’s curricula and the healthcare network. Third-year medical students can elect to spend two weeks on the van while pediatric residents spend at least one month there during their training. The PMC also uses the same electronic medical record as University of Miami clinics, allowing the PMC-based healthcare providers to conveniently reference patient records and make referrals.

Funded by the Children’s Health Fund and founded over twenty-five years ago in New York City, there are fifty PMCs throughout the country, all providing curbside healthcare customized to the unique population serviced by that van. Even with the Affordable Care Act and emerging new medical services, there will always be children falling through the cracks and the PMC will be there for them.

Dr. Lisa Gwynn came out of private practice several years ago to serve as the Medical Director for the South Florida PMC. In a recent interview, she described working with the clinic as a “life-changing experience where I fell in love with the mission of helping children who are really in need.” These children desperately need healthcare yet their barriers to access are just too great. The PMC breaks down the walls and red tape preventing them from going to the doctor and provides them with the care they need to live healthy and successful lives.

The author would like to thank Dr. Lisa Gwynn for her assistance in writing this article and all of the staff members of the South Florida Pediatric Mobile Clinic for their mentorship and service to the South Florida community.
WWAMI – A Five-State Regional Medical Education Program

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WWAMI is a partnership of the University of Washington School of Medicine and the states of Washington, Wyoming, Alaska, Montana and Idaho to provide publicly supported medical education to the citizens of the Northwest. The acronym WWAMI stands for the first letter of each of the five states participating in this medical education program. The WWAMI region covers approximately 28% of the land mass of the United States and has 3.5% of the population. WWAMI was founded in 1971 as WAMI (Wyoming joined in 1996) and had five original goals: 1) provide access for citizens of the Northwest to publicly supported medical education; 2) increase number of primary care physicians and address maldistribution of physicians; 3) create community-based medical education; 4) expand graduate medical education and continuing medical education; and 5) avoid excessive capital costs and duplication of resources by using existing educational infrastructure. Each WWAMI state has physicians who make up the state specific admissions committee and participate in the overall admissions committee for the School of Medicine. WWAMI students spend their first year at the partner University in their home state. The partner Universities are: University of Wyoming, University of Alaska, Anchorage, Montana State University, University of Idaho and in Washington, students can attend either the University of Washington in Seattle or Washington State University in Spokane. Currently, all students are at the University of Washington in Seattle for their 2nd year. A new pilot 2nd year program at Washington State University in Spokane has up to 20 students per year. Students can take their required and elective clerkships in their 3rd and 4th years throughout the WWAMI region. Students may also participate in the WWAMI Rural Integrated Training Experience (WRITE) which is a longitudinal integrated clerkship. Students who do the WRITE program receive credit for the entire family medicine clerkship, the outpatient components of their internal medicine, pediatric and psychiatry clerkships and an elective clerkship.

Required pediatric 3rd year rotations are located in Washington (Seattle, Spokane, Moses Lake, Tacoma, (Continued)
Centralia, Olympia, Wenatchee), Wyoming (Cheyenne, Jackson), Alaska (Anchorage), Montana (Great Falls, Helena, Missoula, Bozeman, Billings) and Idaho (Boise, Pocatello, Idaho Falls). The WRITE sites are located in Washington (Chelan, Ellensburg, Ferndale, Grand Coulee, Moses Lake, Newport, Port Angeles, Port Townsend, Pullman, Shelton), Wyoming (Douglas, Powell, Lander), Alaska (Juneau, Kodiak, Wasilla), Montana (Butte, Dillon, Helena, Lewistown, Libby, Miles City), and Idaho (Hailey, Jerome, McCall, Nampa, Sandpoint). Elective rotations in Pediatrics are offered in Washington (Seattle, Spokane, Tacoma), Wyoming (Ft. Washakie), Alaska (Anchorage), Montana (Billings, Missoula) and Idaho (Boise).

WWAMI has multiple graduate medical education opportunities throughout the five state region. The WWAMI family medicine residency network has over 20 family medicine residency programs including several rural training tracks. There are three internal medicine residency programs outside Seattle in Billings, Boise and Spokane. There is a new psychiatry residency program in Spokane that will accept residents in 2015 and a psychiatry residency track in Idaho where residents spend their first two years in Seattle and the last two years in Idaho. Internal medicine residents from Seattle may choose to do a month long community based rotation in a small community in the WWAMI region.

The pediatric residency program in Seattle requires all residents do an eight week community based rotation during their 2nd year in one of five small communities in the WWAMI region (Bellingham, Port Angeles and Yakima in Washington and Pocatello and Sandpoint in Idaho). A newly developed primary care track in Pediatrics, The Alaska Pediatric Residency Track accepts four new interns a year. These residents spend four months in each of their three years of training in Alaska. The locations that participate in the Alaska Pediatric Residency Track are Anchorage, Bethel, and Fairbanks.

To find out more about WWAMI: [http://www.uwmedicine.org/education/wwami](http://www.uwmedicine.org/education/wwami)
To find out more about pediatric residency training: [http://www.seattlechildrens.org/healthcare-professionals/education/uw-peds/](http://www.seattlechildrens.org/healthcare-professionals/education/uw-peds/)

**Team Peds**

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Medical students training to become pediatricians have their own quirks and needs that are different from many other medical students. Who else proudly wears a shirt advertising the latest diaper cream plastered on the front, a souvenir that they brought home from the most recent AAP National Conference & Exhibition? Having a group that plans activities, provides opportunities to gain experience in the field and gives specific support to these students is an important part of ensuring that the future generation of pediatricians can better serve the world’s children with the best care possible. *(Continued)*
The Florida Atlantic University’s Charles E. Schmidt College of Medicine, a new medical school founded in 2011 has a pediatric interest group, called Team Peds, that is equally as new. This has allowed the group to be innovative and creative in its approach to leading and developing the group. Team Peds’ primary goal is to further students’ knowledge of and interest in pediatric medicine through research, service, and networking experiences in our student community.

Team Peds supports students in finding opportunities to volunteer with children in the community. Whether with an afterschool program or with a toy and diaper drive for the Department of Health, Team Peds members are given the opportunity to serve and learn from children, our future patient population. There are many local organizations that love having medical students come and volunteer. Many of the organizations that Team Peds members work with are found by people who have done previous work with them and through suggestions from faculty.

There is a conventional saying that “it’s not what you know, but who you know that really matters.” Team Peds recognizes the importance of networking with pediatricians in our community and around the nation. Members are encouraged to attend pediatric society meetings at both the local and national level. In addition, speakers from different pediatric subspecialties often visit our medical campus, allowing members to gain some exposure to the different types of career paths in pediatrics, allowing them to have a broader perspective on the pediatric medical specialty. It is always enjoyable to meet like-minded professionals from our community and even around the nation and Team Peds is privileged to have faculty mentors who are willing to put us in contact with pediatricians from all over the country.

Team Peds also facilitates opportunities for members to observe and shadow local pediatricians. Gaining hands-on experience with real patients is invaluable for those of us who are interested in pediatrics. There are various pediatric clinics that students participate in with the supervision of an attending pediatrician.

Research in pediatric medicine is a valuable way to learn about the field, and we seek to facilitate students in finding research opportunities by documenting past pediatric research projects that former students in our school have been involved with. This will provide the future medical students with a list of resources that they can use to identify research opportunities. It also allows them the ability to contact students in different classes, and to collaborate in longitudinal pediatric research projects. Collaboration is a core value of Team Peds and something our group members believe is essential to the future of medicine. In the world of medical school that focuses on adult physiology, adult pathology, adult pharmacology, a pediatric interest group can provide future pediatricians with an environment in which they can learn more about their future patient population through service, research, and professional networking. On top of the great learning experiences group members gain, students also are able to take time away from their busy schedules to spend it with children—an uplifting change of pace in students’ busy schedule. Team Peds has made such an impact at our school that we have won the Outstanding Contribution to Community Service Award from our college of medicine two years in a row. Some Team Peds activities have even been incorporated into the medical school curriculum because they were recognized as important aspects of medical education. Team Peds has been invaluable to those involved with it, and there is no doubt that it would serve students at any medical school well to make the effort to establish their own pediatric interest group.
Climate Change and Child Health

Christine Thang, MS3; David Geffen School of Medicine at UCLA

There is growing evidence that the Earth’s climate is changing. Evidence suggests that global surface temperatures have increased at approximately 1 degree Celsius per century, and temperatures are expected to increase 1.8-4.5 degrees Celsius over the next century. Public health experts anticipate that these changes will have a dramatic impact on global health. The impact of extreme weather events, infectious diseases, and pollution-related illnesses on child health is not often discussed until disasters or epidemics arise. Children are a particularly vulnerable population given their naïve immune systems and dependency on their caregivers for their health.

In an interview with Dr. Cristina Tirado, climate, global health and food expert and professor at the UCLA Fielding School of Public Health, Dr. Tirado explained the effect of global climate change on maternal and child health, as well as food and nutrition security. Dr. Tirado emphasized the fact that children often comprise the at-risk members of a population. The majority of the existing burden of disease attributed to climate change affects children under 5 years of age. Health effects include increased respiratory and diarrheal diseases, changing ranges of vector-borne diseases such as malaria or dengue, increased morbidity and mortality from extreme weather events, and food insecurity among others. As changing climate and weather patterns alter agricultural production, there is an expected decline in caloric availability that will most severely affect the world’s poorest populations—including millions of children. Tirado estimates that, by 2050, the number of children facing food scarcity worldwide will increase by over 20%. Many will face chronic hunger and clean water scarcity.

Climate change has the potential to impact microbial ecology and the growth and survival of pathogens, in effect changing patterns of infectious diseases. Recent climate models have elucidated the spread of vector-borne diseases including Lyme disease in North America and malaria in Africa. With changes to the environment, the incidence of such diseases may occur where once not encountered. The microbial profiles of water sources may change, with a subsequent increase in the prevalence of diarrheal illnesses.

Environmental factors can affect health in innumerable ways. Poor air quality and increased aeroallergen exposure exacerbates cardiopulmonary diseases. Extreme weather events such as heat waves, floods, and droughts will cause an increasing number of injuries and deaths. Research is emerging on heat related health effects including diminished school performance, increased rates of pregnancy complications, and renal effects.

There are multiple methods of mitigating climate change and improving health. These methods include reducing local pollution and emissions of pollutants by shifting to renewables, and increasing energy efficiency. For example, this can be (Continued)
achieved by redesigning communities to promote active transportation and subsequently physical activity.4

There are simple measures pediatrics can take to mitigate the effects of climate change while promoting children’s health. The American Academy of Pediatrics Committee on Environmental Health issued a series of recommendations for pediatrics to incorporate into their practices.5 The committee recommends that pediatrics can encourage families and their children to walk or ride their bikes together not only to live more actively but also to reduce automobile emissions. Pediatricians can also serve as role models through how they manage their practices by demonstrating energy sustainability by conserving energy in the work place and minimizing dependence on automobile travel to the office. As medical experts, pediatricians can work with local and state health departments to strengthen public health infrastructure, disease surveillance, and disaster preparedness. At the trainee level, climate change can be incorporated into medical education and pediatric residency as a concept related to pediatric health. As climate change takes center stage in the public arena, pediatricians and pediatrics-in-training can use this momentum to champion children’s health!

Sibshop and a Pediatric Interest Group Spring Carnival

Breann Kluck, M1; Earth Hassasri, M1; Mayo Medical School

As medical students, we often fall into a routine of learning in a certain way, probably as a result of classroom-based learning during our first two years. It’s not very often that we have the opportunity to expand our newly attained scientific knowledge into the context of the human experience; even less often are we able to do so by hanging out and having fun with a group of school-aged kids. However, that’s exactly what a group of us in the Mayo Pediatrics Interest Group did in mid-February during the Sibshop event, organized by Mayo Clinic Child Life specialists. Held at

the local family fun and athletic center, this event was targeted toward a population that oftentimes doesn’t receive the spotlight: the enduringly brave siblings of kids with special needs.

Following an Olympics theme, the day began with group bonding by decorating a team flag and fleece scarves that corresponded to our team colors. The exciting and engaging day was filled with activities including mini-golf, jumping on inflatables, fun free time, Minute-to-Win-It activities, and completing a capture-the-flag course. All these games incorporated teamwork challenges, reflection time, and Q&A sessions related to being a sibling of a child with a disability. It’s safe to say that the volunteers had just as much fun as the kids and that there was hardly a moment without a smile on someone’s face! Recognizing the (Continued)
challenges that a child with disabilities may bring to a family, we hoped to provide a safe, open environment for the siblings to discuss the problems they faced and explore potential management solutions. Above all, we sought to do this in an empathetic and understanding manner in order to create an environment that is not always possible—but is very much deserved—in their busy households. To the surprise of the volunteers, the children were able to take initiative in brainstorming their own creative solutions related to avoiding bullying, managing conflict, and gaining communication skills with other kids who were facing similar challenges.

While most of the medical students who participated have some interest in pediatrics, some students interested in different specialties joined in the fun just for the sake of it. By serving as team leaders, photographers, and activity station leaders, we were able to be involved in almost every aspect of the day’s activities. This event was particularly special because we were able to spend time with a group of young people who simply needed to take a break and “just be kids”. As eager-to-learn medical students, we were thankful to have the opportunity to reflect on and develop empathy for the challenges of pediatric illness and disability that are not only experienced by the patient, but also by his or her parents and siblings. Additionally, our unique role as first-year medical students allowed us to bridge the gap between patients, their support systems, and providers by serving as student and peer-like role models for the siblings.

Most recently, our Pediatrics Interest Group held a “Land Before Time”-themed Spring Carnival for pediatric inpatients and their siblings. The evening carnival included a “Food Cave” with various treats, “Dino River” where children could fish for prizes, “Moonlight Dance” musical chairs, “Meteor Shower” bean bag toss, “Crater Crafts” with coloring and painting, and even displayed several interactive erupting volcanoes to complement the dinosaur decorations throughout the ward. We made sure to include all kids who were interested in participating—regardless of their mobility—by having a traveling carnival that visited those children in their rooms. We hoped to provide a fun environment as an escape from the oftentimes intimidating hospital, which can constantly serve as a reminder of the kids’ sickness and missing out on fun with their friends.

The volunteers left the carnival with warm hearts and images of the happy smiles we provided to the patients and their siblings (not to mention their parents!), who so infrequently have a taste of the “real world” outside of the hospital walls. Through these activities, we were able to learn that the science of medicine is not the only thing that can heal—the art of healing through kindness, enthusiasm, empathy, and support can be just as important. As future physicians, we are expected to focus on the clinical diagnosis and treatment plan for the patient. With activities such as Sibshop and the Spring Carnival, medical students can learn early on the skills necessary to prioritize, deliver, and become comfortable with the more human aspect of healing and caring for sick individuals, skills that can last throughout their entire careers.
A Case of Chronic Anemia: Blue Rubber Bleb Nevus Syndrome

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HPI:
Patient is a 9 year old female with a history of chronic anemia, recurrent urinary tract infections, and constipation who presented to an outside county clinic because her father thought she looked “pale.” Upon arrival, the patient was noted to have a hemoglobin level (Hgb) of 4.3 (nl: 12-14.2) and transferred to a neighboring children’s hospital emergency center. The patient was admitted and given packed red blood cells until Hgb was 9.1. Patient was subsequently transferred to a larger children’s hospital for further management and higher level of care. Upon further questioning, the patient’s father reported several months of melena. The patient denied any hematochezia, hematemesis, hematuria, epistaxis, abdominal pain, or syncope. The patient has not started menarche. The patient does not have any history of easy bruising or bleeding or any bleeding disorders in the family.

Per father, the patient was initially diagnosed with iron deficiency anemia approximately 4 years ago when the patient presented to the emergency room with a “critical” Hgb level, positive Fecal Occult Blood Test, and transferred to the Intensive Care Unit. GI was consulted for concern of a GI bleed. Esophagogastroduodenoscopy (EGD) and colonoscopy were performed and were both negative for any sources of bleeding. Inflammatory bowel disease studies were also negative. CT Abdomen and Pelvis incidentally showed a calcified mass at the costochondral junction of the right 8th and 9th ribs anteriorly with a percutaneous biopsy indicating benign vascular malformation through true cut needle biopsy and aspiration. Patient was discharged with supplemental iron and continued regular follow-up with GI. Over the past 4 years, the patient has had several episodes of pallor and fatigue that has required three ER visits in which the patient was found to be anemic and treated with iron supplementation.

Hospital Course:
Once admitted, initial labs showed persistent normocytic anemia with a normal iron panel. Meckel’s scan at outside hospital was negative. The patient underwent a repeat EGD and colonoscopy with biopsies that showed diffuse gastric erythema and erosion in the antrum. The rest of the upper GI and lower GI were unremarkable. A pill camera study showed a possible small vascular mass in the distal jejunum and proximal ileum seen suggesting a surgical consult for further evaluation. Given the findings in the small intestine, operative management was decided and the patient was taken to the OR for exploratory laparotomy with push enteroscopy to find the lesion. However, in the OR the patient was noted to have multiple superficial lesions and enteroscopy was deferred. Six venous polypoid lesions were excised with two segmental small bowel resections. Final pathology was consistent with multiple arteriovenous malformations, and the patient was diagnosed with Blue Rubber Bleb Nevus Syndrome (BRBNS). The patient did well post operatively with stable hemoglobin levels and was discharged with close follow-up with a gastroenterologist.

Discussion:
Blue Rubber Bleb Nevus Syndrome (BRBNS) is a rare disorder with multiple vascular malformations in the skin, soft tissues, and gastrointestinal tract. The disorder is also known as Bean Syndrome, named after William Bean in 1958 who first described the appearance of the lesions.1 BRBNS is regarded as a congenital vascular disorder though both sporadic and (Continued)
autosomal dominant inheritance patterns have been described in the literature.\(^2\) Though the age of diagnosis of BRBNS can vary greatly, most patients have a long history of anemia due to chronic bleeding and requiring multiple blood transfusions and supplemental iron. One study described 10 patients who ranged from ages 2 to 36 years at the time of diagnosis and averaged 53 blood transfusions prior to diagnosis.\(^3\)

BRBNS lesions are classically characterized as small, multifocal, and blue-purple in color. They are typically diagnosed by endoscopic procedures, including esophagoduodenoscopy (EGD) and colonoscopy. A pill-cam study is frequently used to evaluate any lesions in the small intestines that cannot be visualized otherwise. The treatment and management of these lesions has been widely debated. Many have suggested the use of anti-angiogenic therapies, including corticosteroids or interferon-alpha, to control the growth of the hemangiomas. However, it has been suggested that BRBNS lesions have been inappropriately labeled as hemangiomas and are in fact non-proliferative vascular malformations that do not regrow after they are removed.\(^3\) Therefore, Fishman et al contest that an aggressive surgical intervention with resection of all lesions is the optimal management. If lesions are seen on pill-cam, intraoperative push enteroscopy is highly recommended to visualize any lesions in the small intestines that need to be resected. In their study, an average of 137 vascular malformations (range 4-557) was found predominantly in the small and large intestines. Of the 10 patients, only one patient did not have complete resolution of bleeding due to incomplete intraluminal evaluation intraoperatively. In our case, push enteroscopy was deferred due to the presence of superficial lesions; however, there is a high probability that there may still be remaining transmural or intraluminal lesions that may result in recurrent bleeding in the future. On the other hand, our patient only had 6 lesions in the small intestine without large intestine involvement, one possible lesion in the chest seen on CT, and no cutaneous lesions, suggesting that she may have been an early diagnosis. Additionally, octreotide has also been described to control acute blood loss and decrease the number of blood transfusions.\(^4\) However, the efficacy of octreotide for long term control of recurrent bleeding is still questionable. There have also been several case reports describing the use of endoscopic band ligation, laser photocoagulopathy, and double balloon enteroscopy, though the evidence remains limited to isolated patients\(^5\)\(^-\)\(^6\).

**Conclusion:**

BRBNS is a rare disorder with multiple cutaneous and gastrointestinal vascular malformations. It should be considered in children with chronic anemia requiring multiple blood transfusions. A thorough skin exam should be performed to identify any cutaneous lesions. Management should include complete evaluation, including EGD, colonoscopy, and pill camera study. If lesions are found, the decision to pursue surgical resection with push enteroscopy should be weighed heavily against less invasive therapies to prevent recurrent bleeding.

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