Greetings SOID Members! I’d like to update you on a few items of importance for our section.

First, as you know, I have been working on behalf of SOID and the AAP with members of other organizations and the American Medical Association on a proposal to develop interprofessional telephone consult codes from an attending physician/qualified health care professional to a specialist physician for opinion and/or treatment advice. In December, 2012, after >12 months of multiple telephone conferences and behind the scenes work, a time-based proposal for 4 physician to physician telephone consult codes was submitted to the full CPT Advisory Committee. Final action on this proposal will be forthcoming at the CPT Advisory May meeting.

Next, the SOID is assisting the CDC to increase the awareness of several “emerging” parasitic diseases in the U.S. population. To help better educate AAP members, there will be a forthcoming AAP News Focus on Subspecialties article regarding Chagas Disease. If you haven’t already done so, please respond to the survey from the CDC, “Can you guess the diagnosis?” to assist the CDC assess the knowledge of pediatricians regarding a specific parasitic infection. Finally, the CDC is also considering other ways to obtain pediatrician input regarding the occurrence of other parasitic diseases, such as neurocysticercosis, in U.S. children.

The SOID Executive Committee is completing a revision of the Vaccine Refusal form which was introduced several years ago and has been available through the AAP. Since the original introduction of this form, new vaccines have been added to the Recommended Routine Childhood Immunization Schedule and more physicians are seeing...
families who refuse 1 or more vaccines. I greatly appreciate the efforts of Ed Rothstein, MD, FAAP, our former SOID Newsletter Editor, who retired from the SOID Executive Committee last year but continues to assist us, in seeing this revision to a successful completion.

Another outstanding educational program is being planned, regarding pediatric infectious diseases and immunizations, for the upcoming NCE in New Orleans. Dr. Tina Tan, SOID Program Chair, and members of the Education Subcommittee are working to ensure that the sessions at the NCE and other meetings with SOID involvement are educational as well as of high quality. We welcome your suggestions regarding future topics for the NCE and other types of educational programming that you feel would be beneficial.

As you know a member discussion board was launched last spring and we encourage you to check out the various topics under discussion and add your own comments, questions or interesting cases. The discussion board is easy to access at: [http://www2.aap.org/sections/infectdis/forum/index.cfm](http://www2.aap.org/sections/infectdis/forum/index.cfm) (AAP ID and password required).

Finally, we will be saying goodbye to Dr. Craig Shapiro, Pediatric Infectious Disease Fellow at Emory University, Atlanta, GA, this summer. Craig has been actively involved as a voting member of the SOID Executive Committee this past year, he has reviewed many materials for the SOID, co-wrote an AAP News article last May, has been instrumental in developing a survey for ID fellows in training (see the article on page 3 of the newsletter) and has been very helpful in co-authoring a special column for fellowship trainees in our SOID Newsletter. Elizabeth Doby, M.D., Pediatric Infectious Disease Fellow at the University of Utah will be our new voting fellow-in-training on the SOID Executive Committee beginning in July and we plan to add another training fellow liaison in the coming months. For information refer to the position description at: [http://www2.aap.org/sections/infectdis/SOID_TF_Call.pdf](http://www2.aap.org/sections/infectdis/SOID_TF_Call.pdf)

As always, please share your ideas, thoughts, or concerns, about the SOID Newsletter, the SOID website and/or any other activities having to do with our AAP Section with me (dmurray@georgiahealth.edu) or Suzanne Kirkwood, SOID staff liaison (skirkwood@aap.org). Thanks for your membership in the AAP and the SOID.

Dennis L. Murray, M.D., FAAP, FIDSA
Professor, Department of Pediatrics
Georgia Health Sciences University
Chair, SOID Executive Committee

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**SOID Volunteers Needed**

**Newsletter Review Articles:**
The editorial staff of the SOID newsletter would like to incorporate a feature that highlights new and interesting infectious disease-related articles. The format will be similar to what is currently used in the Section on International Child Health newsletter ([https://www2.aap.org/sections/ich/pdfs/SOICH_October_2011.pdf](https://www2.aap.org/sections/ich/pdfs/SOICH_October_2011.pdf)). We are seeking 3 Section members who would be asked to contribute content for the spring and fall editions of the newsletter. Each individual would be responsible to review three journals, identify at least one article, and provide a summary of the article for inclusion within the newsletter. If you would like to be considered for one of these positions please submit your CV to Suzanne Kirkwood at skirkwood@aap.org by May 25, 2012.

**Education Subcommittee:**
The Education Subcommittee is responsible to assist the Executive Committee and the Program Chair in the development of educational programming regarding infectious diseases for general pediatricians and infectious diseases physicians. At this time we are seeking general pediatricians and physicians board certified in infectious diseases to serve a three year term on the Subcommittee. If you are interested, please submit your CV to Suzanne Kirkwood at skirkwood@aap.org by June 15, 2012.
The goal of the training fellows' column is to provide current pediatric infectious diseases fellows and those interested in a career in pediatric infectious diseases the tools to make informed career choices.

As part of our effort to provide programming that training fellows find beneficial, we are soliciting feedback in the form of a survey. Your responses will be greatly appreciated and help us to improve the SOID programming directed at training fellows. Your responses to the survey will be anonymous. We invite you to utilize the link below to access the survey.

• Survey for ID training fellows: https://www.surveymonkey.com/s/WLZ8l9I

The Future of Pediatric Infectious Disease Training

Editorial by Craig Shapiro, MD

We have chosen to enter a field of medicine that is unique. Most physicians learn the basis of what they need to practice in their respective fields during the initial years of clinical training. In our case, these first few years of clinical training will prepare us for only part of our future career. As a pediatric infectious diseases specialist, we are frequently required to be both a clinician and a strong academic researcher to maintain and further our career.

The importance of the three-plus years of fellowship cannot be understated. It is during these years of our training that we are supposed to hone our skills for the other piece of our career, the non-clinical portion. Sure, a few will have already entered fellowship with a PhD or MPH; however, most have only scratched the surface of what we will need to learn to become productive researchers. Some of us will extend fellowship a year or two to obtain additional training that may culminate in a master’s degree. However, for most of us, we are expected to be ready to enter a profession where clinical skills alone often are not enough. We rely on the support from our mentors to help guide us in our early academic careers.

Now that we are finally ready to make that transition from trainee to professional, what's next? If you are one of the fortunate ones, there may be a position available for you to stay on as faculty within your own institution. With research funding as difficult as ever to obtain, many graduating fellows will be looking for jobs that offer full salary support at the onset. It is often difficult for many of the smaller institutions to offer full funding, as divisional funding to hire new faculty is limited. There are other ways that an academic pediatric infectious diseases physician can contribute to part of their funding, including hospital epidemiology, medical director for microbiology, assistance with antimicrobial stewardship, educational responsibilities to medical students, residents and fellows, and other hospital and clinic administrative and jobs. However, in the end it is still the funding obtained through grants that is crucial for fellows to create their own opportunities and to increase their attractiveness as a potential faculty member.

While the number of fellowship positions in pediatric infectious diseases has increased over the past ten years, it appears that the number of job opportunities has not kept up. While there are other options, such as working for the government, industry, or even practicing (part-time/full time) as a general pediatrician or hospitalist, if the job postings on the PIDS website are any indication, things are going to continue to be difficult for many graduating fellows in our field.

Continued on Page 4
ID Training Fellows' Column  Continued from Page 3

The key to this equation is the transition to our professional career. Dedicated curriculum to assist fellows with career planning, and guidance in developing other roles that will provide some additional salary support, may help to ease this career transition. The ultimate goal should be to make the transition seamless and open more doors for fellows to become junior faculty. If the future of pediatric infectious diseases is going to continue to grow, we need to think about how we train and transition our fellows to best prepare them for this unique career.

We invite you to post comments about this article on the AAP SOID discussion board (http://www2.aap.org/sections/infectdis/forums/index.cfm - AAP ID and password required)

Do you have an interesting case to share with other Section members? Please send interesting teaching cases to lilly.immergluck@choa.org and access existing cases at: ID case of the month (http://www2.aap.org/sections/infectdis/forums/index.cfm - AAP ID and password required)

Spotlight on Careers in Infectious Diseases

Are you interested in stamping out disease on a national or global scale? Have you ever thought it might be interesting to investigate an outbreak of lassa fever in Africa or cholera in Haiti? Then the Epidemic Intelligence Service through the CDC might be a great option after completion of your fellowship. The Epidemic Intelligence Service (EIS) is a unique 2-year post-graduate training program of service and on-the-job learning for health professionals interested in the practice of applied epidemiology. To learn more about the EIS program check out their website http://www.cdc.gov/EIS/index.html

We welcome your feedback on how to make this column as useful as possible for training fellows. Please feel free to contact us at the email addresses above with any questions or ideas for future editions.

We are also always looking to reach out to those training fellows who may not be members of the AAP. If you know of any training fellows who are not AAP members, please ask them to contact us to find out how they can take advantage of the great benefits that come along with being an AAP and SOID member!

Information from National

Contact Carolyn Mensching at cmensching@aap.org with any questions!

Get Involved in the AAP

A collaborative effort has been launched to encourage AAP members to become more involved in the work of all levels of the AAP. We recognize that not all members will be able to contribute in the same way, but every member has something to contribute! We welcome all commitment levels to move the AAP mission forward. Send an email to getinvolved@aap.org with your interests and we will help you to make the right connection.

Be inspired by viewing the video that debuted at the AAP National Conference & Exhibition! You may share this link broadly to encourage others to get involved as well! http://youtu.be/yz9utLafE_c

Visit the Lead @ AAP website at: http://www.aap.org/moc/leader

We are excited to announce the American Academy of Pediatrics’ Lead @ AAP Website! Lead @ AAP is a comprehensive resource, not only for current AAP leaders but also future leaders and interested members, to learn more about the AAP and how committees, councils, and sections function. We encourage you to take a look and submit a question or comment - we'd love to hear from you!
PediaLink for Fellowship Programs

This new online program is being offered to Fellowship Programs and is designed so that users spend more time learning and less time documenting. Access it at: http://www.pedialink.org and click on the Fellow in Training of Program Director boxes for more information.

Benefits for Training Fellows:
- Create scholarly activity projects
- Document progress on quality improvement projects
- Assess core competencies and personal attributes with the Learning Plan
- As an AAP member there is no additional cost for this program
- Access the program by logging into PediaLink using your AAP ID and password on the home page

Step 1 for all Program Directors – Start using PediaLink for Fellowship programs by contacting us at AddFellow@aap.org with your Name, Program Name, and Subspeciality to connect you to your program.

Benefits for Program Directors
- Document, track, and evaluate your fellows’ progress
- Schedule semi-annual reviews
- Customize tools to fit your program needs
- Not a member of the AAP – no problem we will send you instructions on how to access the site for free just follow Step 1 above.

From the Minutes of the SOID Executive Committee
Meeting of October 17, 2011

Access the the summary of the SOID minutes by following this link:
http://www2.aap.org/url/s12/soid.htm

CDC Survey – Can you guess the diagnosis?

The Centers for Disease Control and Prevention want to test your knowledge. All pediatricians and pediatric subspecialists are invited to participate in a short survey about disease diagnosis by clicking on the following link: https://www.surveymonkey.com/s/pediatriciansurvey The survey will take approximately five minutes to complete and all answers will remain confidential.

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 NCE travel grants to residents or fellows in training with an interest in infectious diseases. Residents and ID Training Fellows may apply for the travel grant through Friday, May 18, 2012 by completing the request form at: http://www2.aap.org/sections/infectdis/TravelAwardFlyer12.pdf
Quality Connections Newsletter

The Winter issue of AAP Quality Connections [http://www2.aap.org/visit/Winter2012QICconnections.pdf] is now available. AAP Quality Connections was launched by the AAP Steering Committee on Quality Improvement and Management (SCOQIM) to communicate timely information and increase awareness of the importance of quality improvement. The newsletter also provides updates on current AAP quality improvement programs and projects.

Highlights from the winter issue follow:

• Improving Access and Efficiency: The Foundation of a Patient-Centered Medical Home
• QI: Coming Full Circle
• National Nephrology Collaborative Uses Quality Improvement to Engage Families
• Building a Quality Improvement Network in Pediatric Cardiology and Cardiovascular Surgery
• BCBS Alternative Care Quality Contract: One Practice’s Experience

For questions regarding this newsletter please contact, Junelle Speller, Senior Health Policy Analyst, Quality Improvement, jspender@aap.org, 847-434-7650 office, 847-434-4996 fax.

AAP and ID Resources and Links

1. Red Book Online: [http://aapredbook.aappublications.org/](http://aapredbook.aappublications.org/) Developed by the American Academy of Pediatrics (AAP) Committee on Infectious Diseases to provide guidance on the manifestations, etiology, epidemiology, diagnosis, and treatment of more than 200 common childhood conditions.

2. Red Book Online Webinars: [http://www2.aap.org/pcorss/webinars/redbook/](http://www2.aap.org/pcorss/webinars/redbook/) View the schedule and information regarding the next webinars and access previous topics.

3. PREP ID Online Self Assessment Program - [http://prepid.aap.org/](http://prepid.aap.org/) This online self-assessment program is developed by leading pediatric infectious diseases specialists for specialists to assist physicians Prepare for Maintenance of Certification™ (MOC) Examinations.

4. Pedialink Hot Topics – [http://pedialink.aap.org/visitor/cme/cme_finder](http://pedialink.aap.org/visitor/cme/cme_finder) Access the four online courses regarding influenza as well as other interesting topics.

5. AAP Immunization Site: [http://www2.aap.org/immunization/](http://www2.aap.org/immunization/) – This site provides information regarding AAP immunization policy and practice guidance as well as numerous resources for practices regarding immunizations.

6. Subspecialty Webpage: [http://www2.aap.org/moc/leader/subspecialists.cfm](http://www2.aap.org/moc/leader/subspecialists.cfm) (AAP login and password required) This page is a resource for pediatric subspecialists and surgical specialists with links to important information that exists on the Academy website that is relevant to subspecialists.

7. LEAD@aap.org. This site provides information for Executive Committees regarding Section management and leadership resources. [http://www2.aap.org/moc/leader/default.cfm?nfstatus=401](http://www2.aap.org/moc/leader/default.cfm?nfstatus=401)

8. AAP Federal Affairs – [http://federaladvocacy.aap.org](http://federaladvocacy.aap.org) (AAP login and password required)

The US Food and Drug Administration convened a public workshop on Ethical and Regulatory Challenges in the Development of Pediatric Medical Countermeasures (MCMs) on February 15-16, 2012 in Rockville, MD. The goal of the meeting was to help clarify issues and discuss recommendations for the development of pediatric MCMs to be available in case of bioterrorism attack, outbreak of an emerging infectious disease and/or natural disaster. These MCMs include stockpiling of supplies including antibiotics, anti-virals, vaccines, biologics and devices for prevention (e.g., anthrax or smallpox vaccine) as well as medical management in case of such an emergency.

MCMs for children pose unique challenges including:
1. Lack of safety and efficacy information for a number of agents.
2. Agents with pediatric indications but not specifically related to bioterrorism use.
3. Agents with an adult indication but without pediatric indication.
4. The need to develop standardized dosing, preparations and devices for rapid dispersion.
5. Specific difficulties with increased cost and shorter shelf life of certain pediatric preparations (e.g., suspensions) for MCMs.

Sessions focused on both scientific and ethical issues involved in the development of pediatric MCMs. A major issue in this regard is the uncertain risk of an event making risk versus benefit assessment difficult. For example would pre-event testing of an agent or vaccine beethically acceptable in the absence of potential direct benefit to the child? Could true informed consent be obtained in the absence of known risk? This inability to fully assess risk is balanced by the need for classified information. Alternatively would administration of a modality as an investigational new drug (IND) be feasible at the time of an event?

Additional issues that need to be addressed include:
1. Further definition of which products need be included for pediatric MCMs and that appropriate formulations are available. Also planning for use of products or devices in varied settings (e.g., health care facility, field, and home).
2. Alternative approaches to approving such products, the acceptability of extrapolating animal model, adult or pharmacologic modeling data to children.
3. Planning pre-event studies where possible and protocols for data collection during and after an event.
4. Regulatory guidelines for pediatric MCMs that might be unique for these agents (e.g., national IRBs).
5. The need for studies in special populations within pediatrics (e.g., neonates, children with decreased renal function).

The American Academy of Pediatrics has been a very active consultant to government agencies on these and related issues and the Academy was well represented at the meeting. Steve Krug, MD, FAAP presented on experience in obtaining approval for pralidoxime (an agent to treat organophosphate exposure) as an example of the process that might need to be applied to utilizing pediatric MCMs. A session on the role of federal policy decisions on pediatric MCM development was organized by the AAP and chaired by Tamar Magarik Haro, AAP. John Bradley, MD, FAAP served as “rapporteur” for the scientific sessions of the meeting. Additional information on MCMs is available at www.fda.gov and the slides from this meeting will be made available on this site.

Ongoing interactions among groups concerned with these issues and federal agencies as assembled at this meeting will hopefully lead to improved planning and maximal protection for children if such an event should occur.
AAP’s Childhood Immunization Support Program (CISP)  
Spring 2012 Update

CISP is a five-year cooperative agreement between the AAP and the CDC. The CISP has been at the AAP since 1999, and this is its third phase of funding. The mission of the CISP is to improve the immunization delivery system for children across the nation. Specific goals are to:

1) Promote quality improvement and best immunization practices in community- and office-based primary care settings and other identified medical homes.
2) Enable pediatricians and pediatric health care professionals to communicate effectively with parents about vaccine benefits.
3) Promote system-wide improvements in the national immunization delivery system.

The CISP provides resources and technical assistance on a variety of immunization and vaccine safety topics to help pediatricians and other child healthcare professionals communicate with parents about vaccine safety issues and the importance of immunizing children within a medical home.

CISP Projects include:

➢ **Immunization Training Guide**

The Immunization Training Guide is a comprehensive online piece designed to assist pediatric office staff in all aspects of immunizing a practice's patients. This customizable tool can be used to educate and properly train physicians, nurse practitioners, physician assistants, nurses, medical assistants, office managers, and other office staff. It was posted online at: [http://www2.aap.org/immunization/pediatricians/trainingguide.html](http://www2.aap.org/immunization/pediatricians/trainingguide.html) in September 2011, with a brief evaluation tool. Since it’s posting, this tool has been downloaded 14,425 times.

➢ **Risk Communication Video Series**

The Risk Communication Video Series is a set of five videos for pediatricians and pediatric residents. The goals of these videos are to teach pediatricians to have effective and productive conversations with parents about immunizations, through using the CASE model, developed by Alison Singer. The video series was posted at: [http://www2.aap.org/immunization/pediatricians/riskcommunicationvideos.html](http://www2.aap.org/immunization/pediatricians/riskcommunicationvideos.html) in September 2011, with a brief evaluation tool. Since it’s posting, this site has been visited 519 times.

➢ **Periodic Survey**

A Periodic Survey of AAP Fellows to assess the capacity, knowledge, and attitudes of pediatricians regarding the recommended immunization schedule and immunization practices will be conducted during the summer and fall of this year. AAP research and CISP staff are currently working with CISP Project Advisory Committee members to finalize the survey questions.

➢ **Dissemination of an EQIPP module featuring best immunization practices**

In 2009 CISP developed an EQIPP module, *Give Your Immunization Rates a Shot in the Arm*. In 2012, the module will be updated and moved to EQIPP's new platform, and will be disseminated to pediatricians in areas with low rates of immunization coverage in 2013. Technical assistance will be offered to those who request it.

➢ **Needs Assessment**

The CISP Needs Assessment conducted in summer 2011 identified areas where pediatricians need continued support from the CISP program. These areas include: promoting influenza vaccination among health care professionals, resources for parents on various vaccine topics, and assistance with catching up patients who are behind on their immunizations. CISP staff plan to develop a summary of these results to distribute to participants.

View more information about CISP and immunizations at: [http://www2.aap.org/immunization/](http://www2.aap.org/immunization/)

Contact Katie Milewski, Program Manager of Immunizations, at kmilewski@aap.org with any questions.
Are You a PIDS Member?

If you are a physicians, doctoral-level scientist, or other person who has training or are in the course of training in infectious diseases or its related disciplines, and who are identified with the discipline of pediatric infectious diseases or its related disciplines through clinical practice, research, teaching, and/or administration activities you are eligible for membership. In addition, physicians and others without formal infectious diseases training are eligible for membership if they are identified with the discipline of pediatric infectious diseases or its related disciplines through clinical practice, research, teaching, administration or any combination of these activities. Resident membership in PIDS is open to persons enrolled in pediatric residency training programs that are approved for credit toward certification by the American Board of Pediatrics, the American Osteopathic Board of Pediatrics, the Royal College of Physicians and Surgeons of Canada, or La Corporation Professionelle des Medecins du Quebec.

The mission of PIDS is to enhance the health of infants, children, and adolescents by promoting excellence in diagnosis, management and understanding of infectious diseases through clinical care, education, research and advocacy. Membership helps you keep abreast of the latest advances in the field through the subscription to the Journal of the Pediatric Infectious Diseases Society included with membership and by attendance at the many educational activities developed by PIDS or by PIDS and the AAP, the Pediatric Academic Societies (PAS), the Infectious Diseases Society of America (IDSA), and other groups. You can also take advantage of or participate in the PIDS advocacy activities that benefit pediatric infectious diseases as a subspecialty and pediatric infectious diseases physicians as a group.

Additional membership benefits include reduced tuition at the PREP-ID review course and other meetings as well as online services on the PIDS website such as the job listing section and the Directory of the Pediatric Infectious Diseases Training Programs.

Please join PIDS in its mission to advance knowledge of pediatric infectious diseases. The dues are $225 for domestic and international members. Residents and Fellows can join for free! To join, download the membership application located on the Homepage of the PIDS website (www.pids.org) and fax or mail to PIDS Headquarters with your remittance. If you have any questions or concerns regarding membership, please contact the Membership Services Department at (703) 299-6764.

From the ACIP Minutes of October, 2011 and February, 2012

The slide sets for the meeting of October 25-26, 2011 have been posted at:
http://www.cdc.gov/vaccines/recs/acip/slides-oct11.htm

The slide sets for the meeting of February 22-23, 2012 have been posted at:
http://www.cdc.gov/vaccines/recs/acip/slides-feb12.htm

Each set contains slides in pdf format.

The minutes of the October meeting are available at:

From the Minutes of the Committee on Infectious Diseases Meeting of October 15-16, 2011

Access the summary of the COID minutes by following this link:
http://www2.aap.org/url/s12/coid.htm
Welcome To Our New 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 Services will take them to an application.

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ID Sessions at Pediatric Academic Societies Meeting
April 28 - May 1, 2012 Boston, MA

For the descriptions of the ID sessions go to:
http://www.pas-meeting.org/2012Boston/Tracks/track_list_ids.asp

For the complete PAS program
go to:
Welcome To Our New Members  Continued from Page 10

A special welcome to training fellows who were automatically added to the Section.
(As of July 1, 2010, Section dues for infectious diseases training fellows were eliminated.)

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Is Your Contact Information Up to Date At the AAP?
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New Policy/Guidelines

General guidelines: Andrea Sperduto, MD, FAAP
(Note: There were no new HIV/AIDS related guidelines to report in this edition.)

I. AAP
   a. Urinary Tract Infection: Clinical Practice Guideline for the Diagnosis and Management of the Initial UTI in Febrile Infants and Children 2 to 24 Months
      -Changes in this revision include criteria for the diagnosis of UTIs and recommendations for imaging.
      http://pediatrics.aappublications.org/content/128/3/595.full.pdf

   b. Poliovirus
      -Statement provides guidance on optimal use of the 3 combination vaccines containing IPV licensed.
      http://pediatrics.aappublications.org/content/128/4/805.full.pdf

   c. Meningococcal Conjugate Vaccines Policy Update: Booster Dose Recommendations
      http://pediatrics.aappublications.org/content/128/6/1213.full.pdf

   d. Additional Recommendations for Use of Tetanus Toxoid, Reduced-Content Diphtheria Toxoid, and Acellular Pertussis Vaccine (Tdap)
      -This statement extends the ages for use of Tdap to: 1) children 7-10 yrs of age and 2) adults >65 yrs of age who have or are likely to have contact with an infant <12 mos old.
      http://pediatrics.aappublications.org/content/128/4/809.full.pdf

   e. Recommendations for the Prevention of Perinatal Group B Streptococcal (GBS) Disease
      Pediatrics 2011;128:611-616.
      -This policy statement reviews and discusses differences between 2002 and 2010 CDC guidelines that are most relevant to pediatric practices.
      http://pediatrics.aappublications.org/content/128/3/611.full.pdf

   f. Recommendations for Administering Hepatitis A Vaccine to Contacts of International Adoptees
      http://pediatrics.aappublications.org/content/128/4/803.full.pdf

   g. Prevention of Varicella: Update of Recommendations for Use of Quadrivalent and Monovalent Varicella Vaccines in Children
      http://pediatrics.aappublications.org/content/128/3/630.full.pdf

   h. Rabies-Prevention Policy Update: New Reduced-Dose Schedule
      http://pediatrics.aappublications.org/content/127/4/785.full.pdf

   i. Recommended Childhood and Adolescent Immunization Schedules-United States, 2012
      Pediatrics 2012;129:385-386
      http://pediatrics.aappublications.org/content/129/2/385.full.pdf

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New Policy/Guideline Reviews Continued from Page 12

j. HPV Vaccine Recommendations
   Pediatrics 2012;129:602-605
   http://pediatrics.aappublications.org/content/129/3/602.full.pdf

k. Recommendations for Prevention and Control of Influenza in Children, 2011-2012
   Pediatrics 2011;128:813-825
   http://pediatrics.aappublications.org/content/128/4/813.full.pdf

l. The Use of Systemic and Topical Fluoroquinolones
   Pediatrics 2011;128:e1034-e1045
   http://pediatrics.aappublications.org/content/128/4/e1034.full.pdf

m. Immunizing Parents and other Close Family Contacts in the Pediatric Office Setting
   Pediatrics 2012;129:1 e247-e253
   http://pediatrics.aappublications.org/content/129/1/e247.full.pdf

II. MMWR
   a. Recommendations on the Use of Quadrivalent Human Papillomavirus Vaccine in Males- Advisory Committee on Immunization Practices (ACIP), 2011
      MMWR December 23, 2011/60(50);1705-8.
      -ACIP recommends use of HPV4 in males aged 13-21 yrs.
      -Vaccination can be started as young as 9 yrs and males aged 22-26 yrs may be vaccinated as well.
      http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6050a3.htm

   b. Immunization of Health-Care Personnel. Recommendations of the Advisory Committee on Immunization Practices (ACIP)
      MMWR November 25, 2011/60(RR07);1-45.
      http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm?s_cid=rr6007a1_e

   c. Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine (Tdap) in Pregnant Women and Persons Who Have or Anticipate Having Close Contact with an Infant Aged <12 Months- Advisory Committee on Immunization Practices (ACIP), 2011
      MMWR October 21, 2011/60(41);1424-1426.
      -This further reinforces vaccination of adults aged 65 yrs and older to help protect infants from pertussis and discusses vaccination of pregnant women during the third or late second trimester (after 20 weeks' gestation).
      http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6041a4.htm?s_cid=mm6041a4_w

   d. Recommendation of the Advisory Committee on Immunization Practices (ACIP) for Use of Quadrivalent Meningococcal Conjugate Vaccine (menACWY-D) Among Children Aged 9 Through 23 Months at Increased Risk for Invasive Meningococcal Disease
      MMWR October 14, 2011/60(40);1391-1392.
      -These recommendations detail the specific risk factors and timing of vaccine doses.
      http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6040a4.htm?s_cid=mm6040a4_e%0d%0a

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III. IDSA

   J Trauma 2011;71:S210-S234.
   - Endorsed by the Infectious Diseases Society of America and the Surgical Infection Society.

b. An Update on Treatment of Genotype 1 Chronic Hepatitis C Virus Infection: 2011 Practice Guideline by
   the American Association for the Study of Liver Diseases
   Hepatology 2011;54:1433-1444.
   - Do not really address pediatric patients

c. The Management of Community-Acquired Pneumonia in Infants and Children Older Than 3 Months of
   Age: Clinical Practice Guidelines by the Pediatric Infectious Diseases Society and the Infectious Disease
   Society of America
   Clin Inf Dis 2011;e1-e52.
   - Recommendations include: hospitalization criteria, diagnostic testing, anti-infective therapy and fol-
     low-up, and adjunctive surgical therapy (for parapneumonic effusions).
Federal Affairs Update - AAP Advocacy on Academic and Subspecialist Issues

For timely updates on federal advocacy for the subspecialist, please take a few minutes to review the Washington Report on Academic and Subspecialist Advocacy available online at:
http://federaladvocacy.aap.org/index.cfm/key/3FEC109E-7706-4D08-A848-B34D5DDD43EF

- Highlights of the newsletter:
  - Updates on Health Care Reform Implementation
  - Budget and Appropriations
  - Pediatric Research
  - Pediatric Workforce/Graduate Medical Education including GME Financing for Children's Hospitals (CHGME) and Pediatric Subspecialty Workforce Loan Repayment Program
  - Drugs and Devices including Drug Shortages and Pediatric Devices Las Implementation and Reauthorization
  - Physician Payment including Medicare and Medicaid Physician Payment

AAP Creates New Listserv, Continues Advocacy on Pediatric Drug Shortages

The AAP launched a new drug shortages listserv to serve as a forum for AAP members to share information about new or ongoing drug shortages affecting pediatric populations. If you are interested in being added to the listserv or learning more about it, please contact Tamar Haro in AAP's Department of Federal Affairs at tharo@aap.org.

To learn more about the Academy's advocacy efforts in this area, please read this AAP News article http://aapnews.aappublications.org/content/32/12/1.1.full on pediatric drug shortages from December 2011.

Dept of Federal Affairs Online Resource Center: Visit the AAP Department of Federal Affairs website at http://federaladvocacy.aap.org to find federal advocacy resources and tools, including:

- Utilize the AAP Advocacy Guide, http://www2.aap.org/moc/advocacyguide/index.cfm an online resource for pediatricians that provides tools, training modules and real-life examples of advocacy work carried out by pediatricians at the local, state and federal levels
- Become a Key Contact! Key Contacts are AAP members who have expressed an interest in federal advocacy, and receive regular e-mail communications from the Department of Federal Affairs with legislative updates and specific requests for action. Armed with the most up-to-date knowledge on federal legislation affecting children and pediatricians, Key Contacts speak up to our nation's leaders during critical decision points in the legislative process. E-mail DOFA at kids1st@aap.org to become a Key Contact today
- Contact and biographical information for your federal legislators
- An Action Center where you can call and e-mail federal legislators directly on current federal child health policy priorities
- Information on how to submit timely opinion pieces to local media outlets
- Fact sheets on health reform implementation and other timely topics
- All recent federal testimony given by AAP experts before the U.S. government on various child health topics
- Additional online resources such as PowerPoint presentations, videos, and other documents on current federal child health policy priorities
Case 1: You are consulted for a worsening skin infection despite seven days of antibiotic therapy, including two days of IV therapy while hospitalized. This 8-month-old white male infant originally presented one week ago to an urgent care facility with two days of diaper rash. The infant was afebrile but somewhat irritable. The rash had begun just below the umbilicus and spread to the left inguinal crease. In the urgent care, two of the six 1-2 cm irregular bullae had ruptured revealing shiny bases. There were no other lesions. After a culture of fluid from a bulla, clindamycin was prescribed (10 mg/kg/dose three times daily).

Two days later the culture revealed methicillin susceptible *Staphylococcus aureus* confirmed to be susceptible to clindamycin by D-test, but the rash was worse (Figure 1) and he had fever to 38.3°C. The rash now extended to the umbilicus and the contralateral inguinal area with more desquamated areas. The antibiotic was switched to cephalaxin, 50 mg/kg/day divided in three daily doses, and topical mupirocin added. Three days later the infant was hospitalized. The rash now involved both inner thighs and the chest, and had clear crusting plus increasing tenderness. Despite 2 days of IV cefazolin, 100 mg/kg/day divided q8 hours, there was no improvement, so you are asked to see the patient.

Your examination shows irregular somewhat scalloped edges to the desquamated areas. The area was reminiscent of an irregularly edged second degree burn. You confirm that the only topical therapy was mupirocin and there had been no thermal or chemical burns. You also note several 5-8 mm lesions on his right malar eminence and the dorsum of the left foot. You scrape the base of a lesion in the diaper area for direct fluorescent antibody (DFA) examination, making the diagnosis. You recommend acyclovir for 5-7 days. There is a dramatic improvement over the next 72 hours.

Case 2: A known MRSA colonized 10 month old black male with eczema failed outpatient oral clindamycin for a presumed MRSA infection of the right hand. He had accidentally cut his forefinger on the lid of a green-bean can 6 days previously. It was originally cleaned, bandaged and treated with triple antibiotic ointment. It seemed to be healing but worsened after 48 hours with erythema and swelling of the distal 2/3 of the finger. There was also tender erythema/induration spreading proximally onto the dorsum of the hand. In the emergency department, he was thought to have pyoderma and a finger tip abscess. He was hospitalized for culture of the skin, an I&D, and IV vancomycin. The surface culture revealed clindamycin resistant MRSA but the I&D sample revealed no growth. After 3 days of vancomycin (trough value = 12 ug/ml), the cellulitis did not improve. Clusters of papular 3-5mm lesions appeared of his legs and feet where his eczema was being treated with topical triamcinolone. The finger tip around the original laceration was macerated and some skin was sloughing. Figure 2 provided by Brandon Newell MD, Section of Dermatology, Children’s Mercy Hospital, Kansas City shows a similar case. Your examination convinces you that this is a whitlow with lymphangitis. You recommend acyclovir. The cellulitis and fingertip improve over the next 72 hours as do the clusters of lesions elsewhere. Later, grandmother reports having kissed the initial injury to calm the infant, and yes she had a “cold sore” at the time.

These cases reflect the fact that *S aureus* has become so common that it is natural and likely correct to assume that it is the cause of most secondary cutaneous infections that have the appearance of cellulitis or small bulla-like lesions.
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In the first case, clinical clues to HSV being the cause of the persistent desquamating condition in the diaper area with extension to other areas include failure to respond to what should have been appropriate antibacterial therapy, and persistent lesions that were more vesicopustules than bullae. Although HSV is usually associated with 2-5 mm clear vesicles, it can cause coalescing vesicular lesions that may simulate small bullae or even small pustules. The delay in diagnosis of the HSV component was likely due to the initial presentation being in part due to MSSA.

In the second case, HSV whitlow, the traumatic laceration with secondary “cellulitis” on an MRSA colonized child made S. aureus seem reasonable as the causal pathogen to the clinicians who initially saw the child. Again a clinical clue that there was another pathogen, in addition to or instead of MRSA, was the persistent cellulitis that should have improved on the antibacterial therapy. For whitlows the usual pathogenesis is autoinoculation, from sucking on the fingers or toes during times of HSV shedding in the saliva. The worsening of the whitlow after I&D is also expected (rather than improvement after I&D with most bacterial abscesses). The incision exposes more distal nerve endings which are afferent pathways for HSV virions to ascend to the regional dorsal root ganglia, where they replicate and then descend back to the same local tissue to increase the infection. Whitlows also can have surrounding cellulitis, but it is a viral cellulitis. The appearance of subcutaneous coalescing small “bubble” lesions on the finger pad or in the periungual areas, or as in this case, the sterile pustules, are more suggestive of HSV.

The new lesions (in addition to the whitlow) not initially being recognized as due to HSV likely was because abnormal skin, i.e. eczema, can cause atypical appearing lesions, particularly if topical immune suppressing agents, such as steroids, are in use. The clusters of lesions on this eczematous child were not classical and appeared more papular than vesicular likely for this reason.

In both cases above, a consultant with a high index of suspicion, made the initial HSV diagnosis by history and physical examination, but confirmed the diagnoses by laboratory (DFA) for the diaper rash lesions or additional historical data (grandmother’s kiss). The culture of the base of a lesion in the diaper area was also positive but it required 2 additional days for results, whereas the DFA results were available in 3 hours. The prompt response to acyclovir therapy also added to the surety of the diagnoses.

The take home message – if suspected cutaneous S. aureus with desquamation or pseudobullae is not responding to appropriate antibacterial therapy, think of other causes. Not all things that look like bullous impetigo or post traumatic cellulitis are necessarily straightforward staphylococcal or even group A streptococcal disease, which rarely can cause lesions that are bullous-like. Other conditions to consider in the differential diagnosis of bullous lesions in infants include nonaccidental trauma, thermal burns, cutaneous bullous hypersensitivity reaction, bullous erythema multiforme (EM) and very rarely infantile mastocytoma. The history should be helpful in identifying thermal burns and even nonaccidental trauma, as should the pattern of bullae and associated lesions. There should be mucosal involvement with EM.

The frequency and likelihood of recurrent whitlows has been reported to be 23% (Szinnai et al 2001). Children with eczema likely have more frequent recurrences depending on the state of their eczema and the degree of cutaneous immune suppressive therapy. Frequent recurrences (>3 in a 12 month period) have been used as rationale for suppressive acyclovir therapy, but the risk for neutropenia in infants on chronic acyclovir suppression should be considered.

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