Chair’s Letter

Greetings SOID Members! Greetings also to AAP State Chapter Presidents and Executive Directors as well as Pediatric Infectious Diseases (ID) Fellowship Program Directors receiving this Newsletter. The Section on Infectious Diseases, as part of our new strategic plan, is attempting to reach out to both state AAP Chapters and Pediatric ID training programs to increase their knowledge of SOID’s activities and to potentially increase our SOID membership.

In terms of the interprofessional telephone consult codes which I mentioned in previous SOID Newsletters, all four codes approved last year by the AMA CPT Editorial Board were assigned Relative Value Units (RVUs) at the AMA/Specialty Society RVS Committee (RUC) meeting. A huge Thank You to Linda Walsh, Director, Division of Health Care Finance and Quality Improvement, at the AAP and to Dr. Steven Krug (AAP RUC member) for their invaluable assistance both before and during the RUC meeting. In fact, the SOID was recognized for this achievement at the AAP Annual Leadership Forum (ALF) recently held in March. The RVUs assigned are embargoed until published by the Center for Medicare and Medicaid Services (CMS) later this year. It is my hope that these codes, which I have worked on for three plus years, will be in place for 2014, and many pediatric subspecialists, especially those in Pediatric Infectious Diseases, will be able to see some benefit for the numerous telephone consults they perform yearly.

Speaking of consults, in November 2012, in the state where I practice, Georgia, Medicaid eliminated both inpatient and outpatient consult codes, changing them to codes Medicare recommended after eliminating consult codes in

Continued on Page 2
2010. A major reason why Medicare instituted this change was that as many as 75% of the physician consult charges filed by physicians did not fulfill Medicare guidelines. In Georgia, this change by Medicaid will result in both significant financial and productivity (RVUs) decreases, primarily to pediatric subspecialties. Our state (GA) AAP Chapter is currently attempting to reverse this decision by legislative means.

At our last SOID Executive Committee meeting in October, we finished our Strategic Plan for the next 3 years. A few highlights of this plan, in which many of you may be interested, include:

1. Develop joint Section programs at the NCE with other AAP Sections and Councils. For 2014 the SOID will be working with the Section on Allergy and Immunology as well as with the Section on Perinatal Pediatrics.
2. Explore the idea of sponsoring a Visiting Professorship Program.
3. Explore an opportunity to partner with the Pediatric Infectious Diseases Society (PIDS) to develop and implement an ID workforce survey.
4. Appoint an ID Training Fellow to the SOID’s Education Subcommittee.
5. Collaborating with PIDS, explore ways to further develop career planning resources for ID fellows-in-training.
6. Through our connection with AAP Chapters, include articles in the SOID Newsletter highlighting Chapter ID activities and geographically related ID issues, as well as increase awareness of members of the SOID as a group of experts, especially for state advocacy efforts related to vaccines and other ID topics.
7. Finally, we have a large number of general pediatricians interested in infectious diseases who are members of SOID. The SOID Executive Committee wants to develop a needs assessment tool that can be used to access the educational and practice needs of these general pediatricians regarding ID-related issues.

I would like to acknowledge the contributions of Dr. Beth Doby, who, this summer, will be completing her two years of service on the SOID Executive Committee. Beth, along with Dr. Andrea Hahn, the other Pediatric ID Training Liaison on the Executive Committee, are working on an article “What is an antimicrobial steward” for the May, 2013 issue of AAP News as well as participating in the development of career planning resources for training fellows (see #5 above).

Under Dr. Tina Tan’s capable leadership, the Education Subcommittee has completed a Pedialink Application for Challenging ID Cases (pertussis, vaccine hesitancy, C. difficile infections, and travel medicine) and hope to secure funding to move forward in the development of this course. Additionally, plans for PREP ID 2013, which will be held in Chicago, Illinois on July 22 – 27, 2013, are progressing on schedule. PREP ID is a joint program between AAP’s SOID and PIDS. Drs. Mike Marcy (SOID Co-Chair and our 2012 SOID Lifetime Education Award recipient) and David Hunstad (PIDS Co-Chair) are leading the Planning Group and are supported by Drs. Lilly Immergluck (SOID), Dwight Powell (SOID), Lorry Rubin (PIDS) and Gordon Schutze (PIDS). Look for more information regarding registration for this course in this edition of the newsletter. Of special note, the course includes an “Infectious Diseases in Clinical Practice Track” focusing on topics of interest for the general pediatrician, family practice physicians and other allied health professionals with an interest in infectious diseases.

Finally, several SOID members have written to me commenting about the superb quality of our Newsletter. I want to thank Drs. Jane Carnazzo and Jennifer Read for their creative leadership as SOID Newsletter Co-Editors. I also want to express my sincere gratitude to Suzanne Kirkwood as our AAP SOID Staff Liaison. Suzanne “puts it all together” and, without her dedication and commitment, neither I nor the other members of the SOID Executive Committee would be nearly as effective. As always, the SOID Executive Committee and the AAP want to be responsive to your needs and interests. Please contact Suzanne Kirkwood skirkwood@aap.org or me (dmurray@gru.edu – please note new e-mail address) if you have concerns or have ideas for your organization, the SOID. Thanks!

Until the Fall, 2013 Newsletter have an enjoyable Spring and Summer.

Dennis L. Murray, MD, FAAP, FIDSA
Professor, Department of Pediatrics
Chief, Pediatric Infectious Diseases
Georgia Health Sciences University
Augusta, GA
and
Chair, SOID Executive Committee
Advocacy: Creating Moments for Change to Occur

By Andrea Hahn, MD

This February, I was fortunate to attend the 2013 Advocacy Training Session of the American Academy of Pediatrics. The topic of our advocacy for children's health was gun violence prevention. In the wake of the Sandy Hook tragedy in Newtown, Connecticut, the issue of gun violence and its effect on children is again brought to the forefront of our thoughts and concerns. Media coverage of the mass shooting continued through January, and in February, just after the inauguration of President Obama, a young girl who performed with her school band at the event was killed by gun violence in Chicago. Although this may seem outside the scope of infectious disease pediatricians, it is important to note that firearms cause 15 times as many deaths as infections and are one of the top three causes of death among America's youth.

The training session began with a discussion of the five major approaches promoted by the AAP to help keep children safe with regards to firearms. These include promoting safe and responsible gun ownership, conducting research to discover effective methods to prevent gun violence, supporting strong gun safety legislation, assuring access to quality mental health care, and reducing exposure to media violence. In the afternoon, participants took the opportunity to meet with their elected representatives in Congress.

It is important that we as pediatricians speak for the needs of children, as they cannot speak for themselves. While the debate on the correct balance between the rights of gun owners and the degree to which gun safety should be legislated is currently a hot topic in Washington DC, now is a good time to share your thoughts with your elected members of Congress. Regardless of our views on the matter, we can all agree that children deserve to feel safe in their homes, schools, and communities.

Additional information regarding the Academy's advocacy efforts related to gun control, keeping children safe and resources for pediatricians are at: http://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Pages/AAPFederalGunViolencePreventionRecommendationstoWhiteHouse.aspx

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!
Anthrax continues to be a viable threat in the United States. Although the last bioterror anthrax exposure in the United States through the post office occurred in 2001, and federal legislation mandating enhanced readiness for Bioterror and All-Hazards Preparedness passed in 2006, there has been a recent emphasis in continued disaster preparedness.

The CDC has recently approached the AAP to help update their anthrax policy which will provide recommendations on management of an anthrax bioterror event, including recommendations for treatment and prophylaxis. Over the past year, 4 workshops have occurred on: 1) on treatment and prophylaxis (with participants from the Infectious Diseases Society of America (IDSA); 2) on management of serious infections with antibiotics, antitoxins, and immunizations; 3) on management of pregnant and postpartum women (with fetal implications); and finally 4) on pediatric issues. With very welcome collaboration between CDC and AAP, this last meeting (Nov 14-15, 2012), was held as a jointly-sponsored workshop at the CDC headquarters office in Atlanta. The prime AAP partner is the Disaster Planning Advisory Council (DPAC), Steve Krug (Emergency Medicine and Chair of DPAC) and Laura Aird (AAP DPAC Manager) doing the planning and conducting of the conference. There has been pediatric infectious diseases participation at each of the previous CDC meetings, which allowed for some continuity for this meeting in the context of the others, each of which lead to a formal CDC document. Georgina Peacock, MD, MPH, the CDC liaison to the DPAC, also played a prominent role and moderated the conference.

One major goal of this process is to create an AAP Clinical Report, developed by the Academy groups: DPAC and Committee on Infectious Diseases (COID). It will go through the usual AAP review/advise/approve process that pertains to all AAP policy. The SOID Executive Committee will have the opportunity to review a draft of this document and provide feedback. The current plan is to have this document come from both AAP and CDC, requiring formal approval from both organizations. The CDC has agreed to collaborate as partners in this effort (which is crucial in making sure that all parties have influence on the final documents and will allow for creation of an AAP Clinical Report that is in harmony with CDC recommendations).

For this meeting, three Working Groups were formed: Antibiotics Workgroup; a Vaccine Post-exposure Prophylaxis Workgroup; and an Antitoxins and Other Treatments Workgroup.

With respect to antibiotics, this group covered the antibiotics for treatment of meningitis, of systemic disease, of cutaneous anthrax, and post-exposure prophylaxis, including new recommendations for oral convalescent therapy of acute infection, recommendations for breast-feeding mothers, and recommendations for newborn infants.

Data were reviewed and discussed on the use of antitoxin preparations (no pediatric data yet), and the use of vaccine (no pediatric data yet). The use of vaccine, pre-bioterror event, has been the subject of earlier workshops with National Biodefense Science Board and the FDA last year, with AAP presenting our concerns to the Presidential Commission for the Study on Bioethical Issues, regarding our view that it would be ethical to study a limited number of children for immunogenicity and safety, so that vaccine could be quickly and easily made available in a bioterror event. The FDA and CDC are working hard to figure out how vaccine can be made available to all children who need it, while collecting some data on safety and efficacy, either as a compressed phase 1-3 study, or perhaps under an emergency use authorization (EUA). This remains an area of active discussion.

The AAP Clinical Report will also have some background information on the clinical disease and its diagnosis (even though bioterror-related disease may not be similar to naturally occurring disease), as well as information regarding communication between AAP/CDC and providers, and between providers and families during a disaster. The first draft of the pediatric anthrax clinical report was shared at the November 2012 meeting. A second draft is under review by the CDC, with plans for publication in the spring or summer, 2013.
Review of the Recent Infectious Disease Literature

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


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

146 children presented to one of 3 pediatric centers in Sweden between 1996 and 2002 with Lyme neuroborreliosis (LNB) defined as: (1) neurologic symptoms attributable to neuroborreliosis; (2) CSF pleocytosis and; (3) detection of IgG or IGM specific antibodies to B. burgdorferi in the CSF. Of these, 84 children were re-examined and completed a questionnaire; 84 control children were selected from the Swedish National Register of Statistics and were matched to cases for age, gender, and area of residence. All cases underwent a standardized, detailed neurological examination. All case and control subjects completed a questionnaire concerning current constitutional and school performance symptoms.

At follow up, 16 children (19%) with LNB had objective neurologic sequelae: persistent Bell's palsy (11), persistent neuropathy other than Bell's palsy (4), abnormal Romberg's test (3), impaired fine motor skills (3), vibratory or sensation deficit (2) and hemiparesis following stroke (1). Seven (8%) of children with LNB had possible neurological sequelae temporally associated with infection but that were non-specific in nature; these included paresthesias and polyneuropathies.

Forty percent of children with LNB and 49% of controls did not self-report any neurologic symptoms on the questionnaire. Significantly more children with LNB self-reported facial problems, vertigo, or pain, numbness or weakness of the extremities than control subjects. Of interest, headache (38% and 33%) and fatigue (34% and 23%) were the most common self-reported symptoms in controls and cases, respectively.

Reviewer's commentary
Misconceptions about the sequelae of Lyme neuroborreliosis are widespread in the lay community. Headaches, chronic fatigue, and changes in school performance are among the perceived abnormalities that follow infection. In this study, the incidence of these symptoms among children with proven LNB were no different than the rates in matched controls.

This study also underscores the prevalence rate of long term neurologic sequelae in children with LNB. Not only is facial nerve paralysis the most common problem noted, but 21% of children with VIIth paralysis at presentation continue to have paralysis at long term follow-up. Also of interest was the high rate of residual polyneuropathies, unsteady gait, and impaired fine motor skills identified in children with remote LNB. Together these observations suggest that longer follow up for these patients is required. Interventions including occupational and physical therapy may also be warranted.


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

Continued on Page 6
Lumbar puncture is a commonly performed procedure in pediatrics and pediatric infectious diseases physicians are often consulted to help with the interpretation of CSF laboratory results, especially for a patient who has been pre-treated with antibiotics where the culture result may reflect a false negative result. Another frequently encountered consult question is the interpretation of CSF parameters after a patient has had a seizure. Two articles, recently published in *The Journal of Pediatrics*, will greatly assist physicians in interpreting CSF results within these contexts.

In the first article, Srinivasan et al performed a prospective, multi-site study to characterize clinically relevant CSF reference ranges in term and preterm (<37 weeks gestation) infants less than 6 months of age who were hospitalized in an NICU including those who had received prior antibiotics and who were undergoing a sepsis evaluation. Patients were excluded if they had >500 RBCs/μL (eliminating those patients who might have had an IVH), bacterial meningitis, bacteremia or other known reasons for a CSF pleocytosis. Of the 677 infants enrolled, 318 infants met inclusion criteria, 47% were preterm, 62% were ≤7 days old, and 72% had received antibiotics before the lumbar puncture. The upper reference limit of the CSF WBC count was 12 cells/μL in preterm and 14 cells/μL in term infants. CSF protein levels were significantly higher in preterm infants with upper reference limit 209 mg/dL vs 159 mg/dL in term; P<0.001 and declined with advancing postnatal age in both groups; preterm P=0.008, term P<0.001. CSF glucose levels did not differ in term and preterm infants. Antibiotic exposure did not significantly affect WBC, protein or glucose values. Contrary to current dogma, CSF WBC counts did not differ between preterm and term infants during the first week of life and beyond. CSF WBC values did not decline significantly with increasing postnatal age in either preterm or term infants. CSF protein levels were higher and declined more slowly with postnatal age in preterm infants compared with term infants.

**Reviewer's Commentary:**
Having normative CSF values for hospitalized, preterm infants is especially helpful to clinicians since this population is often pre-exposed to antibiotics prior to lumbar puncture because of a clinician's concern for cardiorespiratory instability at the time of the sepsis evaluation. However these results may not be generalizable to febrile infants presenting in ERs and the high proportion of antibiotic-pretreated patients could have led to the inclusion of infants with partially treated meningitis as well as some with viral CNS infections. Since these patients had LPs performed because of concerns for sepsis, the reference ranges reported might not reflect a truly healthy patient population. Additionally, these results are not generalizable to patients with traumatic LPs, which is another patient group where CSF interpretation is challenging.

In the second article, Frank et al performed a prospective, multi-center study of 200 patients with fever-associated status epilepticus (FSE) defined as a single seizure or a series of seizures without interim recovery lasting ≥30 minutes that otherwise met the definition of a febrile seizure (defined as a provoked seizure in which the only identifiable reason was fever). CNS infection or other pathologic conditions were excluded. 136 underwent a non-traumatic LP, defined as <1000 RBCs/mm³. Patients who had an LP performed were younger than those who did not have an LP performed (p<0.001), were less likely to have had a prior febrile seizure (p=0.033), had a longer median duration of FSE (p<0.001) and were more likely to have had a focal FSE (p=0.03). 96.2% had ≤3 WBCs/mm³. Mean CSF protein levels was 22 mg/dL (range 8-137 mg/dL). Only 2.3% had a CSF protein level of >60 mg/dL. The authors were unable to show a statistically significant correlation between protein levels and seizure duration. The mean glucose level was 89.6 mg/dL with a range of 46-201 mg/dL.

**Reviewer's Commentary:**
These findings confirm that FSE rarely causes CSF pleocytosis. Additionally, CSF glucose and protein levels were unremarkable and temperature, age, seizure focality and duration did not affect results. The authors rightly concluded that unexplained CSF pleocytosis after seizures should prompt a thorough clinical search for cause and should not be attributed to the seizure.


*Continued on Page 7*
Chilean investigators performed a randomized, observer-blind, placebo-controlled study of a four-component meningococcal serogroup B vaccine (4CMenB) in healthy adolescents aged 11-17 years. The vaccine consisted of recombinant protein antigens-neisserial adhesion A, factor H binding protein, and *Neisseria* heparin binding antigen together with outer membrane vesicles (OMV) from a specific *N. meningitidis* strain. Subjects received one, two, or three doses of 4CMenB at 1 month, 2 month, or 6 month intervals. Immunogenicity was assessed as serum bactericidal activity using human complement (hSBAbba) against three reference strains for individual vaccine antigens, and assessed by ELISA against the fourth strain. Participants were randomized to 5 groups to receive one dose, two doses 1 or 2 months apart, or three doses of 4CMenB; or three doses of placebo, with an additional three booster groups. All subjects received at least one dose of 4CMenB. Geometric mean titers and proportions of participants with hSBAbba titers of ≥4 were calculated.

Overall, 1631 adolescents (mean age 13.8 years) received at least one dose of 4CMenB. After 2 or 3 doses, 99-100% of recipients had hSBAbba titres of ≥4 against test strains, compared with 92-97% after 1 dose (p<0.0145) and 29-50% after placebo. At 6 months, 91-100% of participants still had titers of ≥4 for each reference strain after 2 or 3 doses, but only 73-76% after a single dose. Seroresponse rates reached 99-100% for each strain after the second or third doses at 6 months. Local and systemic reaction rates were similar after each 4CMenB injection, did not increase with subsequent doses, but remained higher than placebo. No vaccine-related serious adverse events were reported.

**Reviewer's Commentary:** Infection with MenB represents a significant proportion of invasive meningococcal disease (IMD), both in young infants and in individuals in areas where routine use of MenC conjugate vaccine has resulted in proportional decline in MenC IMD. (1) Development of an immunogenic target for MenB has been elusive because the MenB capsular polysaccharide is antigenically similar to human neural cell glycopeptides and is poorly immunogenic. Combined with *Neisseria* OMV’s, 4CmernB includes three major antigens identified by reverse vaccinology (2) that play important roles in the organism's survival, function, and/or virulence. This study provides evidence for an immunogenic adolescent 4CMenB vaccine schedule of two doses, 1-6 months apart, to provide protection against MenB infection. The extent of protection against MenB variants circulating worldwide will need to be determined by national surveys. Such monitoring is necessary to detect potential emergence of MenB strains not covered by this recombinant vaccine. 4CMenB, however, is a step forward in the development of a safe and immunogenic MenB vaccine in adolescents. 4CMenB studies in infants have had similar promising results. (3) Importantly, the vaccine might afford protection against non-group B strains since antigens represented in the vaccine are common to other meningococcal serogroups, as well.

**References:**

1. Dull PM, McIntosh ED. Meningococcal vaccine development – from glycoconjugates against MenACWY to proteins against MenB – potential for broad protection against meningococcal disease. Vaccine 2012;30(S):B18-35.
Federal Affairs Update: Pediatric Infectious Disease Specialists: Sign Up for Medicaid Payment Increase

The Affordable Care Act includes a historic investment to expand access to Medicaid for children, and we want to make sure you know about it. As of January 1, Medicaid payment rates are raised to at least Medicare rates for primary care and immunization services.

An American Academy of Pediatrics (AAP) analysis of billing data estimates that pediatric infectious disease specialists stand to receive an average 47.4 percent increase in Medicaid revenue as a result of the increase. But you must sign up with your state to receive these increased payments.

Board-certified pediatric infectious disease specialists (certified by the American Board of Pediatrics) automatically qualify for the payment increase. However, eligible pediatricians must sign up to receive it. States may have their own reasonable deadlines for pediatricians to sign up (“self-attest”) for the increase, and many of these deadlines are happening within the next month. Pediatric infectious disease specialists who are not board certified by ABP can also be eligible and self-attest if at least 60% of their Medicaid services for the previous year are for the primary care services specified for the payment increase.

There is still time for you to apply. If a pediatrician signs up by the state's deadline, the Medicaid payment increase will be retroactive to January 1. Pediatricians and other eligible physicians who apply after a state's deadline will still receive the increase in payment moving forward; it just will not be retroactive to the beginning of the year. For this reason, all eligible pediatricians are encouraged to sign up as soon as possible.

The increase applies to E/M and immunization services and runs from 2013-2014. The Academy will aim to extend the provision into a permanent investment in children's health.

Sign up to receive the increased payments:

1. Sign up for the increased payments with your state. Visit www.aap.org/medicaidpaymentincrease for an interactive chart that includes state self-attestation forms and other resources on where your state stands.
2. If your state does not yet have a form or other means for you to apply, contact your state AAP chapter’s executive director or speak to your state Medicaid office to learn of your state's plans for implementing the payment increase and how to sign up as soon as possible.

Questions?
If you have questions on how the increase will take effect in your state, please do not hesitate to contact the AAP Division of State Government Affairs at stgov@aap.org or (800) 433-9016 ext. 7799. Learn more about the payment increase at www.aap.org/medicaidpaymentincrease. We'll include updated fact sheets, a state specific status chart and other resources/articles here.

If you have questions about subspecialty eligibility for the increase, please contact James Baumberger in the AAP Department of Federal Affairs at jbaumberger@aap.org.

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 17, 2013 by completing the request form at: http://www2.aap.org/sections/infectdis/TravelAwardFlyer13.pdf
PREP ID: A Comprehensive Review and Update of Pediatric Infectious Diseases

The next PREP ID course will be held in Chicago, Illinois on July 22-27, 2013. PREP ID is co-sponsored by the AAP Section on Infectious Diseases and the Pediatric Infectious Diseases Society.

You should attend PREP®:ID if you are:

• Preparing to participate in the Subspecialty Certifying Examination in Pediatric Infectious Diseases to be administered by the American Board of Pediatrics.
• Preparing to participate in the Program for Maintenance of Certification™ (MOC).
• A pediatrician or family physician interested in a unique review and update of pediatric infectious diseases that can be applied to daily practice. Check out the ID in Clinical Practice Track.
• A pediatric infectious diseases specialist interested in a comprehensive review and update of pediatric infectious diseases.

Participants may earn a maximum of 39.75 AMA PRA Category 1 Credits™ Additional information regarding the location, course content, faculty and registration can be found at: http://pedialink.aap.org/visitor/cme/cme_finder

SOID and PIDS members receive a discount on registration rates – see the website and brochure for more details!

Please note: Online registration is not available for Section members. Register using one of the following options:

Call toll-free: 866/TH-E-AAP1 (866/843-2271)

Mail the registration form with payment to:
American Academy of Pediatrics/Registration
2862 Eagle Way
Chicago, Illinois 60678-1028

Fax this form to: 847/228-5059 or 847/228-0604

Newly Revised AAP Refusal to Vaccinate Form Now Available

The AAP "Documenting Parental Refusal to Have Their Children Vaccinated" form was developed by the Section on Infectious Diseases Executive Committee (SOID) as a resource for pediatricians when talking with parents who are hesitant or refuse to have their children fully vaccinated. The newly revised form as well as other practice resources that address common causes for parental hesitancy or refusal to vaccinate can be accessed on the AAP Immunization (http://www2.aap.org/immunization/pediatricians/refusaltovaccinate.html) and the SOID websites (http://www2.aap.org/sections/infectdis/resources.cfm)
Highlights of the Committee on Infectious Diseases (COID)  
Meeting of November 12-13, 2012

AAP policy statements under development
1. Policy Statement: Raw Milk
3. Clinical Report: Judicious Use of Antibiotics (collaborative project with CDC)
4. Clinical Report: Anthrax (collaborative project with AAP Council on Disaster Preparedness and CDC)
5. Policy Statement: Influenza 2013-14

The following AAP clinical practice guidelines are in the process of development:
1. Fever in Infants Under 3 Months of Age
2. Management of Sinusitis
3. Management of Bronchiolitis in Infants and Young Children

Guidelines in Progress with External Organizations
1. Immunization of Immunosuppressed Children (IDSA)
2. Kawasaki Disease and Endocarditis with Committee on Cardiovascular Disease in the Young (AHA)
3. Prevention & Treatment of Opportunistic Infection/HIV (DHHS)
4. Diagnosis and Management of Bone and Joint Infections (IDSA/PIDS)

The COID will consider the development of new policy regarding the following topics: polio end-game strategy, non-therapeutic use of antibiotics in animal agriculture (revision of technical report), vaccine hesitancy, thimerosal, and adolescent vaccination, infection control in organized sports, and prevention and treatment of congenital toxoplasmosis.

AAP Global Vaccine Advocacy Update
The Global Immunization Program Project Advisory Committee (PAC) serves in an advisory role for two grants focused on global immunization advocacy efforts – a three year grant from the Bill and Melinda Gates Foundation and a one year grant from the UN.

Dr. Yvonne (Bonnie) Maldonado
Dr. Walter Orenstein
Dr. Michael Brady
Dr. Margaret (Meg) Fisher - Chair
Dr. Louis Cooper – Vice Chair
Dr. Linda Arnold
Dr. Kathy Edwards
Dr. Janet Englund
Dr. Shawn Baltivala
Dr. Donna Staton
Dr. Tina Tan

The following activities were highlighted:
• A new global immunizations website is now live: [http://www2.aap.org/international/immunization/default.html](http://www2.aap.org/international/immunization/default.html)
• On December 8th and 9th, 2011 a group of AAP’s international health experts (Drs. Linda Arnold, Shawn Baltivala, Lou Cooper, Margaret Fisher, Thomas McInerny, Bonnie Maldonado, and Donna Staton) joined ONE for an
advocacy day on Capitol Hill followed by a day at the White House to talk with officials about why it is important to preserve American health programs that save millions of lives all over the world.

• The International Pediatric Association (IPA) partnership on immunizations is helping gather information on the various member countries. Currently the IPA Immunization Committee has a survey out to all the member societies in an effort to identify immunizations covered by local governments and rates.

• Recruited > 50 pediatricians as US Global Immunization Advocacy Champions.

• Launch of the Shot@Life mobile phone application in partnership with the UN Foundation. Alanna Levine, MD, FAAP launched the app at the Social Good Summit during the UNGA week on September 22nd. AAP was responsible for reviewing and providing the technical information for this app.

• Ongoing partnership work with PATH, IPA, and GAVI on thimerosal negotiations in the UNEP treaty. AAP has been working closely to advocate to National Pediatric Associations to take action with their Ministries of Health on this issue. The AAP played a part in and supported the IPA and Uruguayan Pediatric Society in attending the June UNEP INC4 Meeting in Uruguay; representatives made statements based on the AAP new recommendations for the use of thimerosal in vaccines. Read statement here: http://aapnews.aappublications.org/content/early/2012/06/01/aapnews.20120601-1

• AAP and IPA leadership awarded vaccine advocacy sub-grants to the pediatric societies of the United Kingdom, Russia, and Spain.

• Global Immunization Champion and FAAP participation in partner events. Champions were present at local Shot@Life events in New York, Utah, and California. PAC chair and co-chair, Meg Fisher, MD, FAAP and Louis Cooper, MD, FAAP attended the Measles and Rubella Initiative Annual Meeting in September 2012. Bonnie Maldonado, MD, FAAP attended the Global Polio Partners Meeting at WHO in November 2012.

• UNF and AAP have developed creative materials, messages, and a strategy for in-office awareness and patient/parent engagement using Shot@Life adhesive bandages during routine immunization pediatric office visits, and a pilot test of this is complete in 30 pediatric practices. Feedback from the pilot practices is being evaluated to roll-out the educational program to a larger cohort of pediatric practices.

• Members of our PAC have been active in academic and conference presentations about global immunizations.

AAP Celebrates Red Book 75th Anniversary

The American Academy of Pediatrics (AAP) is proud to announce that 2013 marks the 75th year since the inception of the widely used Red Book® infectious disease reference.

First published in 1938, the AAP Red Book® rapidly became a standard-setting guide to the diagnosis, management, prevention, and control of myriad pediatric conditions. Generations of infectious disease specialists, pediatric and family practitioners, and public health professionals have relied on it for expert recommendations from the AAP Committee on Infectious Diseases and hundreds of physician contributors.

The Red Book® continues to evolve, keeping pace with cutting-edge clinical advances and information delivery formats. Today’s Red Book® family comprises both the traditional print edition and several electronic versions that make its rich content available wherever needed, including at the point of care:

• The complete new 29th Edition in downloadable, fully searchable AAP eBook format

• Red Book® Online, providing web-based access to the full 29th Edition text (English and Spanish), a unique library of some 2,500 color images, and continual updates and alerts on infectious disease developments - http://aapredbook.aappublications.org/

• New Red Book mobile app—available at no extra charge to Red Book® Online subscribers—delivering convenient offline access to Apple and Android device users
Chapter Corner: Utah Chapter Participant in Immunization Protection in Child Care (IPiCC) Project

Ensuring that all children are fully immunized against vaccine-preventable diseases is a critical public health issue. Child care programs are key targets for efforts to increase the proportion of infants and young children who are fully immunized against vaccine-preventable diseases. The primary objective of CDC-funded Immunization Protection in Child Care (IPiCC) project is to rigorously examine current state, local government, and child care providers’ efforts and barriers to ensuring that all enrolled children are up-to-date for required immunizations and to evaluate strategies to improve immunization coverage in child care programs.

The goals of IPiCC are to: 1) describe Utah state government activities to ensure compliance of child care programs with state immunization requirements and identify barriers to ensuring compliance; 2) describe child care provider knowledge, attitudes, and activities related to ensuring that all children are up-to-date for required immunizations and identify barriers to ensuring up-to-date status; and 3) evaluate interventions to ensure that all children enrolled in child care programs are up-to-date for required immunizations.

Ongoing interventions include a pilot randomized controlled trial in child care programs to determine whether the use of an immunization educational module or a quality improvement intervention will improve child care providers’ knowledge, attitudes, and activities about immunizations and increase the proportion of children who are up-to-date for required immunizations. The IPiCC project will help identifying evidence-based best practices that can be recommended by the CDC and other national organizations to state and local government agencies and child care programs to help ensure that children in child care settings are fully immunized.

Additional information regarding the IPiCC program can be found at: [www.IPiCC.org](http://www.IPiCC.org) or contact Julie H. Shakib DO, MPH at julie.shakib@hsc.utah.edu.

---

CDC Conference: Epidemiology and Prevention of Vaccine-Preventable Diseases

October 10-11, 2013 – Chicago, Illinois

Are You Up-to-Date? Vaccination is a field that’s always changing. It’s as important for you to stay current on vaccine recommendations as it is for your patients to stay up-to-date on their shots. Here’s your chance to connect with national experts from the CDC’s National Center for Immunization and Respiratory Diseases. This comprehensive two-day course will give you the very latest information on vaccines and the diseases they prevent. Take advantage of the reduced registration cost for AAP members. For more information regarding registration, hotel accommodations, continuing education credits and more at: [http://goo.gl/1UdJg](http://goo.gl/1UdJg)


Chapter Corner is a new feature to the newsletter. If you would like to share information regarding “emerging infectious diseases topics” that are occurring in your state and/or new or successful infectious diseases related initiatives we would be happy to highlight it in future edition of the newsletter. Contact Suzanne Kirkwood at [skirkwood@aap.org](mailto:skirkwood@aap.org) for any questions.
ID Pearls and Other Gems:
What is new and what may seem new with dog/cat bites

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

The change of seasons means that those who care for children will be seeing more animal bites. The main fear surrounding animal bites is rabies. But that is not what we will cover in this article. A recently reported study by my colleagues in Kansas City looked into *Staphylococcus aureus* as a pathogen in dog/cat bites. (1) There were several interesting findings.

The data on age, gender, and bite distribution were consistent with previous studies. Of 741 animal-bite patients in the retrospective study, 84% (N = 624) were bitten by a dog, and 52% (N = 389) were 6–13 years of age. Most wounds were superficial (53%), with the distribution being face (48%), arms/hands (31%) and legs (18%). This is the expected predominant age and anatomic distribution based on prior studies. (2) **NOTE:** Bite wounds to the hands have a high risk of infection and any suspicion of tendon, joint or compartment injury warrants appropriate surgical consultation. Key points to consider:

1. **S. aureus is uncommon as a pathogen in wounds after dog/cat bites.**
   Infection was diagnosed in 51 (7%) patients. In this study, infection risk was highest with crush wounds (adjusted odds ratio [aOR], 27.9; 95% [CI], 3.6–213.1) and cat bites (aOR, 4.1; 95% [CI], 2.0–8.6). The infection rate in the study was somewhat less than the 10-15% expected in dog-bites per the 2012 AAP Redbook (Page 203) and much less than the 50% expected rate after cat bites. This difference in cats vs. dog bites has been thought to be due to the puncture wound nature of cat bites as opposed to the tissue-tearing bites of dogs. (Figures 1 and 2)

   Only 29/51 infected wounds in this study (1) had cultures. Pathogens were detected in 15 (52%): 10 *Pasteurella multocida*, 2 methicillin-susceptible *S aureus* (MSSA), one *Streptococcus pyogenes*, and 2 -hemolytic streptococcus. No MRSA was detected. These results are in keeping with those from the era when MRSA was not as frequent in skin and soft tissue infections, and they reflect oral flora of dogs and cats. Other organisms that may be expected are *Capnocytophaga spp.*, anaerobes, or *Neisseria spp*. (3) Remember when you see such potentially infected bite wounds that anaerobic cultures are as important as aerobic cultures. These may require special transport medium.

2. **Most clinicians did not choose the optimum drug to treat already infected wounds.** Amoxicillin/clavulanate, the recommended first line drug for dog/cat bite infections, was the most common antibiotic used to treat these infected bites but only in 23 (45%). Clindamycin plus either trimethoprim-sulfamethoxazole or an extended spectrum cephalosporin should be used in penicillin allergic patients.

3. **Antibiotic prophylaxis was provided for most who presented prior to infection and the appropriate drug was prescribed.** Overall, 451/690 (65%) patients received prophylaxis. Amoxicillin/clavulanate, the recommended drug (AAP 2012 Redbook, page 206, Table 2.19) was given in 384 (85%), and the recommended alternative antibiotic regimen, clindamycin plus trimethoprim-sulfamethoxazole, was given in 9 (2%). Of the 58 who did not receive

*Continued on Page 14*
the appropriate drugs for prophylaxis, cephalaxin, cefdinir, and amoxicillin were most commonly used.

4. Most clinicians prescribe prophylaxis for too long. More than the AAP recommended duration of 2–3 days of prophylaxis was prescribed in 94%, and was >7 days in 244 and 4–7 days in 180.

Summary: Crush wounds and cat bites were independent risk factors for infection per this study. Previously reported risk factors of female gender, complicated wound needing debridement, and a full-thickness injury were not. *S. aureus* was not a common pathogen (4%) in this study despite its frequency in other post-trauma skin infection and a previously reported 11% rate in one prior study. (4)

Bottom Line: So when the next animal bite needs your care, amoxicillin/clavulanate is still the appropriate drug for both prophylaxis and empiric treatment of the penicillin non-allergic patient. Clindamycin plus either trimethoprim-sulfamethoxazole or an extended spectrum cephalosporin should be used instead for penicillin allergic patients. Only 2-3 days of antibiotic should be prescribed for prophylaxis.

And don't forget the tetanus vaccine inquiry (page 707 of AAP 2012 Redbook; Table on wound management page 709). Finally, the rabies section of the AAP 2012 Redbook begins on page 600 and the important table on prophylaxis recommendations is on page 603.

References:


New Resource: Pediatric Preparedness Resource Kit

The AAP developed The Pediatric Preparedness Resource Kit (http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Pages/Pediatric-Preparedness-Resource-Kit.aspx) in response to the 2009 H1N1 pandemic. This resource allows for pediatricians, public health leaders and other pediatric care providers to assess what is already happening in their community or state, and help determine what needs to be done before an emergency or disaster. The kit will promote collaborative discussions and decision making about pediatric preparedness planning.

Physicians who care for children are encouraged to use the resource materials found in the kit to develop strategic partnerships, increase partner engagement, identify strengths and challenges for pediatric preparedness planning, and establish communication networks to ensure that the needs of children are addressed during a pandemic or other emergency.

Public health officials are invited to review the contents of the kit to increase their awareness of issues relevant to pediatric preparedness and strategies for partnering with pediatricians and AAP chapters.

The Kit includes information on strategies to achieve the following:

• Including Pediatric Care Providers in State-Level Decision-Making
• Promoting Strategic Communications and Systematic Messaging
• Prioritizing Within and Among High-Risk Groups
• Developing State Action Plans
• Establishing Pediatric Advisory Councils or Children’s Preparedness Coalitions
• AAP Chapter Contacts for Disaster Preparedness

ID Sessions at Pediatric Academic Societies Meeting
May 4-7, 2013 Washington, DC

For the descriptions of the ID sessions go to: http://www.pas-meeting.org/2013DC/Tracks/track_list_ids.asp

For the complete PAS program go to: http://www.pas-meeting.org/2013DC/Preliminary_Guide/PremProgramALL.pdf
Welcome to our New SOID Members

If you know of others who might be interested in joining the Academy and the Section please have them call 1-800-433-9016 ext 5885 or go to www.aap.org. The 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

<table>
<thead>
<tr>
<th>AAP Fellows and Candidate Members</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Natascha Ching, MD, FAAP</td>
<td>Nizar Maraqa, MD, FAAP</td>
</tr>
<tr>
<td>Austin, TX</td>
<td>Jacksonville, FL</td>
</tr>
<tr>
<td>Jason Halegoua, MD, PhD, FAAP</td>
<td>Shaun Morris, MD, FAAP</td>
</tr>
<tr>
<td>Medford, NY</td>
<td>Toronto, ON</td>
</tr>
<tr>
<td>John Manaloor, MD, FAAP</td>
<td>Richard Turner, MD, FAAP</td>
</tr>
<tr>
<td>Carmel, IN</td>
<td>Beavercreek, OH</td>
</tr>
<tr>
<td>Richard Mansfield, DO, FAAP</td>
<td>Sadie West, MD, FAAP</td>
</tr>
<tr>
<td>Columbus, GA</td>
<td>Cheyenne, WY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>International Members</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Feda Al Gharabli, MD</td>
<td>Francisco Martinez Cabruja, MD</td>
</tr>
<tr>
<td>Amman, Jordan</td>
<td>Santo Domingo, DR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resident Members</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Avika Dixit, MBBS</td>
<td>Julia Hoover, MD</td>
</tr>
<tr>
<td>Indianapolis, IN</td>
<td>Philadelphia, PA</td>
</tr>
</tbody>
</table>

Continued on Page 17
Welcome to our New SOID Members  Continued from Page 16

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.)

<table>
<thead>
<tr>
<th>Name</th>
<th>City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ciji Arthur, MD</td>
<td>Little Rock, AR</td>
</tr>
<tr>
<td>Gayatri Mirani, MD</td>
<td>Metairie, LA</td>
</tr>
<tr>
<td>Natalie Bannettiis, MD</td>
<td>Brooklyn, NY</td>
</tr>
<tr>
<td>Sruti Nadimpalli, MD</td>
<td>New York, NY</td>
</tr>
<tr>
<td>Leena Bhattacharya, MD</td>
<td>Chicago, IL</td>
</tr>
<tr>
<td>Colleen Nash, MD</td>
<td>Chicago, IL</td>
</tr>
<tr>
<td>Adetinuke Boyd, MD</td>
<td>Baltimore, MD</td>
</tr>
<tr>
<td>Andrew Nuibe, MD</td>
<td>Salt Lake City, UT</td>
</tr>
<tr>
<td>Christine Casas, MD</td>
<td>Houston, TX</td>
</tr>
<tr>
<td>Anoop Pulickal, MD</td>
<td>Warwick, RI</td>
</tr>
<tr>
<td>Ann Chahroudi, MD, PhD</td>
<td>Decatur, GA</td>
</tr>
<tr>
<td>David Rosen, MD</td>
<td>Brentwood, MO</td>
</tr>
<tr>
<td>Natalie Daily Garnes, MD</td>
<td>Houston, TX</td>
</tr>
<tr>
<td>Birju Shah, MD, MPH</td>
<td>Warwick, RI</td>
</tr>
<tr>
<td>Jasmeen Dara, MD</td>
<td>New York, NY</td>
</tr>
<tr>
<td>Amanda Shaw, MD</td>
<td>Spring, TX</td>
</tr>
<tr>
<td>Annabelle de St. Maurice, MD</td>
<td>Nashville, TN</td>
</tr>
<tr>
<td>Debbie-Ann Shirley, MB, BS</td>
<td>Baltimore, MD</td>
</tr>
<tr>
<td>Jessica Ericson, MD</td>
<td>Durham, NC</td>
</tr>
<tr>
<td>Leigh Sweet, MD</td>
<td>Houston, TX</td>
</tr>
<tr>
<td>Julie Frere, MD</td>
<td>Montreal, QC</td>
</tr>
<tr>
<td>Prabha Viswanathan, MD</td>
<td>Boyds, MD</td>
</tr>
<tr>
<td>Ashlesha Kaushik, MD</td>
<td>Dallas, TX</td>
</tr>
<tr>
<td>Joshua Watson, MD</td>
<td>Columbus, OH</td>
</tr>
<tr>
<td>Rima Khasawneh, MBBS</td>
<td>Bellevue, NE</td>
</tr>
<tr>
<td>Dawood Yusef, MD</td>
<td>Parma, OH</td>
</tr>
<tr>
<td>Larry Kociolek, MD</td>
<td>Frankfort, IL</td>
</tr>
<tr>
<td>Philip Zachariah, MD</td>
<td>New York, NY</td>
</tr>
<tr>
<td>Marie-Astrid Lefebvre, MD</td>
<td>Montreal, QC</td>
</tr>
<tr>
<td>Christine Zamastil, MD</td>
<td>Columbus, OH</td>
</tr>
<tr>
<td>Elizabeth Lucas, MD</td>
<td>Columbus, OH</td>
</tr>
</tbody>
</table>
New Policy/Guidelines
Andrea Sperduto, MD FAAP

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

I. AAP
-Recommendations give for age at which testing is appropriate (younger infants have higher rates of asymptomatic carriage) and for treatment.
http://pediatrics.aappublications.org/content/131/1/196.full.html
Related AAP News article: http://aapnews.aappublications.org/content/34/1/1.2.full.pdf

-Because the only intervention to completely prevent HIV transmission via human milk is not to breastfeed, in the United States, where clean water and affordable replacement feeding are available, the American Academy of Pediatrics recommends that HIV-infected mothers not breastfeed their infants, regardless of maternal viral load and antiretroviral therapy.
http://pediatrics.aappublications.org/content/131/2/391.abstract?rss=1
Related AAP News Article: http://aapnews.aappublications.org/content/34/2/28.full.pdf

-Use of serological and virological studies to determine risk of HSV transmission to asymptomatic neonates and tailor management accordingly via evaluation and treatment algorithms.
http://pediatrics.aappublications.org/content/early/2013/01/23/peds.2012-3216
Related AAP News article: http://aapnews.aappublications.org/content/34/2/30.full.pdf

d. Recommended Childhood and Adolescent Immunization Schedules-United States, 2013, Pediatrics2013;131:2 397-398
http://pediatrics.aappublications.org/content/131/2/397.full.pdf
Related AAP News Article: http://aapnews.aappublications.org/content/34/2/1.1.full.pdf

II. MMWR
-Included is a table of specific underlying medical conditions, which vaccine(s) are recommended and to whom one needs to revaccinate.
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6140a4.htm

-Hib-MenCY-TT[MenHibrix, GlaxoSmithKline] is recommended ONLY for infants at increased risk for meningococcal disease (functional asplenia such as sickle cell disease identified by newborn screening, asplenia, complement component deficiencies identified by family history).
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6203a3.htm

Continued on Page 19
New Policy/Guidelines Continued from Page 18

c. Update to CDC’s Sexually Transmitted Diseases Treatment Guidelines, 2010: Oral Cephalosporins No Longer a Recommended Treatment for Gonococcal Infections


- CDC no longer recommends cefixime at any dose as a first-line regimen for treatment of gonococcal infections due to increased antimicrobial resistance. If used need patient to return in 1 week for test-of-cure.
- CDC recommends combination treatment with ceftriaxone IM and either azithromycin orally or doxycycline orally.

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6131a3.htm?s_cid=mm6131a3_w

III. IDSA


- The guidelines update 2002 recommendations.
- Discusses diagnosis, management and antibiotic choices and dosing.
- Discusses chronic pharyngeal carriers of group A strep.
- Penicillin and amoxicillin remain treatments of choice.
- For penicillin allergic patients: oral cephalosporins (for those patients who do not have immediate (anaphylactic-type) hypersensitivity to penicillin), erythromycin, clarithromycin or azithromycin.


- Use of antimicrobial agents for prevention of surgical-site infections (SSIs).
- Focus on primary perioperative prophylaxis.
- Focuses on ages 1 year- adults (does not address preterm or full term newborns or infants).
- In most cases, the data in pediatric patients are limited and have been extrapolated from adult data. Nearly all recommendations are based on expert opinion.

Update on HIV Guidelines

Jennifer S. Read, MD, MS, MPH, DTM&H, FAAP

Guidelines for the use of antiretrovirals are available at: http://aidsinfo.nih.gov/guidelines, and are updated periodically. Changes in the guidelines regarding two groups of patients [1). HIV-infected pregnant women and their infants; and 2). HIV-infected children] were to incorporate new data.


Key changes are located in the following sections:
   a. Lessons from clinical trials of antiretroviral interventions to reduce perinatal transmission of HIV;
   b. Preconception counseling and care for HIV-infected women of childbearing age;
   c. Antepartum care;
   d. Recommendations for use of antiretroviral drugs during pregnancy;
   e. HIV-infected pregnant women who are antiretroviral-naïve;
   f. HIV-infected pregnant women who are currently receiving antiretroviral therapy;
   g. Special situations - failure of viral suppression;
   h. Special considerations regarding the use of antiretroviral drugs by HIV-infected pregnant women and their infants;
      i. Intrapartum care; and
   j. Postpartum care.


Key changes are located in the following sections:
   a. Diagnosis of HIV infection;
   b. When to start antiretroviral therapy;
   c. What drugs to start: initial combination therapy for antiretroviral treatment-naïve children;
   d. Management of treatment-experienced infants, children, and adolescents;
   e. Specific issues in adolescents; and
   f. Pediatric antiretroviral drug information.
The Section on Infectious Diseases Leadership Roster

Dennis L. Murray, MD, FAAP
Georgia Health Sciences University
Children's Medical Center
1446 Harper St.
BG-1107A
Augusta, GA 30912-0012
Phone: 706/721-4725
Fax: 706/721-6812
EM: DMURRAY@gru.edu

Jane Carnazzo, MD, FAAP
Children's Physicians, Spring Valley
4224 S. 50th St.
Omaha NE 68117 - 1332
Phone: 402/955-7474
Fax: 402/955-7476
EM: jmcarnazzo@cox.net

Leonard R. Krilov, MD FAAP
Chief, Pediatric Infectious Diseases
Vice Chairman, Department of Pediatrics
Children's Medical Center
Winthrop University Hospital
120 Mineola Blvd, Suite 210
Mineola, NY 11501-4077
Professor of Pediatrics
State University of New York
Stony Brook School of Medicine
Telephone: 516/663-4600 or 516/663-9414
Fax: 516/663-3793
EM: kkrilov@winthrop.org

Tina Tan, MD, FAAP
Attending, Division of Infectious Diseases
Ann & Robert H. Lurie Children's Hospital of Chicago
Professor of Pediatrics,
Northwestern University Feinberg School of Medicine
Telephone: 773/880-4187
Fax: 773/880-8226
EM: titan@luriechildrens.org

Kenneth Zangwill, MD, FAAP
Co-Director, Infection Prevention and Control
Division of Pediatric Infectious Diseases
Harbor-UCLA Medical Center
Professor of Pediatrics
David Geffen School of Medicine at UCLA
1124 W. Carson St.
Torrance, CA 90502-2004
Phone: 310/781-3636
Fax: 310-972-2962
EM: kzangwill@labiomed.org

ID TRAINING FELLOW LIAISONS
Beth Doby, MD
Division of Pediatrics
University of Utah
295 Chipeta Way
Salt Lake City, UT 84108
Telephone: (801) 581-2121
EM: beth.doby@hsc.utah.edu

Andrea Hahn, MD
University of Cincinnati College of Med/PedsID
3333 Burnet Ave
Cincinnati, OH 45229-3026
Telephone: 513/626-6629
EM: Andrea.Hahn@cchmc.org

PROGRAM CHAIRPERSON
Tina Tan, MD, FAAP
Attending, Division of Infectious Diseases
Ann & Robert H. Lurie Children's Hospital of Chicago
Professor of Pediatrics,
Northwestern University Feinberg School of Medicine
Telephone: 773/880-4187
Fax: 773/880-8226
EM: titan@luriechildrens.org

NC&E PLANNING GROUP REPRESENTATIVE
Laurence Bruce Givner, MD FAAP
Professor and Vice Chair for Clinical Affairs
Department of Pediatrics
Chief, Pediatric Infectious Diseases
Wake Forest University School of Medicine
Chief, Pediatric Medicine
Brenner Children's Hospital
Medical Center Blvd
Winston Salem, NC 27157-0001
Phone: (336) 716-2613
Fax: (336)716-9699
EM: lgivner@wfubmc.edu

NOMINATIONS CHAIRPERSON
Dwight Powell, MD, FAAP
Emeritus Professor of Pediatrics
Nationwide Children's Hospital
Pediatric Infectious Diseases
700 Children's Drive Ed 154
Columbus, OH 43205-2664
Phone: (614)722-4459
Fax: (614)722-4458
EM: Dwight.Powell@nationwidechildrens.org

Continued on Page 22
SOID Leadership Roster  Continued from Page 21

**RBRVS CHAIRPERSON**
Margaret Ikeda, MD, FAAP  
Moose Hill Pediatrics  
11 Flying Point  
Branford, CT 06405  
Phone: 203/488-2296  
Fax: 203/458-6960  
EM: ockeda26@hotmail.com

**WEBSITE CONTENT DIRECTOR**
Lilly Immergluck, MD FAAP  
Associate Professor of Pediatrics,  
Morehouse School of Medicine  
Pediatric Infectious Disease Specialist,  
Children's Healthcare of Atlanta (CHOA)  
Morehouse School of Medicine  
720 Westview Dr., SW  
Atlanta, GA 30310-1495  
Phone: 404/756-1330  
Fax: 404/756-1357  
EM: lilly.immergluck@choa.org

**NEWSLETTER EDITOR**
Jane M. Carnazzo, MD FAAP  
EM: jmrcarnazzo@cox.net  
Jennifer S. Read, MD, MS, MPH, DTM&H, FAAP  
EM: read@post.harvard.edu

**NEWSLETTER EDITORIAL BOARD**
Andrea Sperduto, MD, FAAP  
EM: sperdua@ccf.org  
Christopher J. Harrison MD, FAAP  
EM: cjharrison@cmh.edu  
Stephen Aronoff, MD, FAAP  
EM: Stephen.Aronoff@tuhs.temple.edu

Jane Gould, MD FAAP  
EM: Jane.Gould@DrexelMed.edu
Sherman Alter, MD FAAP  
EM: sherman.alter@wright.edu
William Hitchcock, MD FAAP  
EM: wmphitchcockmd@san.rr.com
Beth Doby, MD  
EM: beth.doby@hsc.utah.edu
Andrea Hahn, MD  
EM: Andrea.Hahn@cchmc.org

**EDUCATION SUBCOMMITTEE**
Mayssa Abuali, MD, FAAP
Sherman Alter, MD, FAAP
Robert Frenck, MD FAAP
William Hitchcock, MD, FAAP
Lilly Immergluck, MD FAAP
Sabah Kalyoussef, MD, FAAP
Jennifer Read, MD, MS, MPH, DTM&H, FAAP
James Wilde, MD, FAAP
Charles Woods, MD FAAP

**AAP STAFF**
Suzanne Kirkwood, MS
Manager, Section of Infectious Diseases
Phone: 800/433-9016, ext. 7648
Fax: 847/434-8000
EM: skirkwood@aap.org

Mark A. Krajekci
Journal Production Specialist