

PEDIATRIC PERSPECTIVES

A Quarterly Publication for HDVCH Referring Physicians



President's Message

Welcome to the second edition of *Pediatric Perspectives*. We have had excellent feedback from many of you regarding the first issue. I hope we continue to delight and inform you with the second.

This issue features articles in several "hot topic" areas. Steven Pastyrnak, Ph.D., division chief, psychology services at Helen DeVos Children's Hospital, explains the new recommendations from the American Academy of Pediatrics on autism screening. Meanwhile, adolescent medicine specialist Lisa Lowery, M.D., discusses vaccinations for pre-adolescents and teenagers, including the Gardasil vaccine. She even provides specific responses to parents who balk at having their daughters vaccinated.

In addition, pediatric gastroenterologist Deborah Cloney, M.D., has some tips to help you manage constipation in your patients (did you know it's one of the most common complaints seen in pediatric offices?).

If you're hearing from parents worried about exposing their children to radiation during diagnostic procedures, you'll definitely want to read the article "Radiation Safety in Children," in which Bradford W. Betz, M.D., division chief, radiology at Helen DeVos Children's Hospital and a radiologist with Advanced Radiology Services, P.C., explains the hospital's ALARA—As Low As Reasonably Possible—program.

With the start of fall athletic training come sports injuries. Many can be handled in your office, and pediatric orthopedic surgeon Jeffrey A. Cassidy, M.D. discusses which ones and when it's time to refer.

In the meantime, we now have more than 160 pediatric specialists in 40 pediatric specialties as we continue to welcome new physicians to our staff who bring us expanded access and capability in orthopaedics, hematology/oncology, child protection, plastic surgery, neurology and neonatology.

Lastly, construction of the new Helen DeVos Children's Hospital reaches skyward more each day. Now that steel is being erected, the scope of the building is taking shape and it is exciting to see our progress toward occupancy in early 2011.

As always, I appreciate your feedback and suggestions. Enjoy the rest of your summer.

All the best,

Bob Connors, M.D., President
Helen DeVos Children's Hospital

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Screening for Autism in Primary Care Practices

Just the Facts

- Pediatricians and family physicians should routinely screen toddlers for autism spectrum disorders (ASD)
- If ASD is suspected, refer to the appropriate specialists as soon as possible
- Don't wait to see if the child will "grow out of it."

The definition and diagnosis of autism has expanded significantly in the past 20 years, particularly with the introduction of the concept "autism spectrum disorders (ASD)." These disorders are not rare; a 2004 survey found that nearly half (44%) of primary care physicians reported they cared for at least 10% of children with some form of autism. However, just 8% of physicians reported that they routinely screened for the disorder.

This is concerning given evidence that shows that the clear benefits of treatment for very young children, and recommendations that intervention begin even before reaching a definitive diagnosis. As Steven Pastyrnak, PhD., division chief, psychology, at Helen DeVos Children's Hospital, notes: "The general consensus among clinicians is that the earlier you identify the child, the earlier you can intervene."

In addition, parents have become increasingly aware of autism because of significant media coverage. Thus, it is important that community pediatricians and family practitioners feel comfortable in their ability to recognize the condition and routinely screen their patients in the toddler years for the clinical signs of autism. To support them in this effort, the American Academy of Pediatrics (AAP) published new guidelines in November 2007 on the identification and evaluation of children with autism spectrum disorders.ⁱⁱⁱ The guidelines call for the following:

- Addressing concerns about development at each preventive care visit through the first 5 years
- Scheduling a "problem-targeted" visit because of an ASD concern
- Continuing developmental surveillance throughout the first 5 years:
 - Eliciting and attending to the parents concerns about their child's development
 - Documenting and maintaining a developmental history
 - Making accurate observations of the child
 - Identifying the risk and protective factors

- Maintaining an accurate record and documenting the process and finding

Table One depicts the algorithm the AAP recommends for identifying and evaluating autism spectrum disorders.

Even if the screening results in some false positives, that's OK, said Dr. Pastyrnak. "It's better to be cautious and evaluate more kids, some of whom might be false positives, than to be conservative. When it comes to autism, the traditional 'let's wait and see' approach is not effective."

Referring for an autism-spectrum disorder

If you suspect a child has an ASD, refer to a qualified clinician or agency within the community for a more comprehensive evaluation. In some communities, the evaluation process may start with the family's local intermediate school district or Early On agency. A hospital-based autism clinic like the one at Helen DeVos Children's Hospital can provide a comprehensive evaluation that includes a through review of the child's medical history.



Table One: Identifying and Evaluating Children for Autism Spectrum Disorders (ASD)

Score 1 for each risk factor	
	Sibling with ASD
	Parental concern
	Other caregiver concern
	Patient younger than 18 months old
	Pediatrician concern
	Total

Score = 0	Appointment for anything other than 18–24 month visit
	• Schedule next preventive visit and reassess
Score = 0	Appointment is for 18–24 month visit
	<ul style="list-style-type: none"> • Administer ASD-specific screening tool. The Modified-Checklist for Autism (M-CHAT) is a good option in the primary care setting. The tool is available free online at www.dbped.org/media/mchat.pdf. It takes 5 to 10 minutes to administer and can be completed during a typical office visit. • Results positive or concerning: Provide parental education and refer for comprehensive ASD evaluation, early intervention/early childhood education services, and audiologic evaluation. Also schedule follow-up visit to reassess. • Results not concerning, or negative: Schedule next preventive visit and reassess.
Score = 0	Appointment is not for 18–24 month visit
	• Schedule next preventive visit and reassess

Score = 1	Patient is at least 18 months old <ul style="list-style-type: none"> • Administer ASD-specific screening tool • Results positive or concerning: Provide parental education, and refer for comprehensive ASD evaluation, early intervention/early childhood education services, and audiologic evaluation. Also schedule a follow-up visit to reassess. • Results not positive or concerning: Provide parental education; schedule an additional visit within 1 month, then reevaluate.
Score = 1	Patient younger than 18 months old <ul style="list-style-type: none"> • Evaluate social communication skills • Results positive or concerning: Provide parental education and refer for comprehensive ASD evaluation, early intervention/early childhood education services, and audiologic evaluation. • Results not positive or concerning: Provide parental education; schedule an additional visit within 1 month, then reevaluate.
Score = 2+	<ul style="list-style-type: none"> • Provide parental education and refer for comprehensive ASD evaluation, early intervention/early childhood education services, and audiologic evaluation. Also schedule follow-up visit.

ⁱ Dosreis S, Weiner CL, Johnson L, Newschaffer CJ. Autism spectrum disorder screening and management practices among general pediatric providers. *J Dev Behav Pediatr.* 2006 Apr;27(2 Suppl):S88-94

ⁱⁱ Myers SM, Johnson CP; American Academy of Pediatrics Council on Children With Disabilities. Management of children with autism spectrum disorders. *Pediatrics.* 2007 Nov;120(5):1162-82. Epub 2007 Oct 29. Review.

ⁱⁱⁱ Johnson CP, Myers SM; American Academy of Pediatrics Council on Children With Disabilities. Identification and evaluation of children with autism spectrum disorders. *Pediatrics.* 2007 Nov;120(5):1183-215. Epub 2007 Oct 29.

Radiation Safety in Children

A controversial report published in *The New England Journal of Medicine* in late November suggesting that as many as 2 percent of all cancers in the United States might be due to radiation from CT scans received extensive media attention, bringing questions from parents throughout the region about the safety of x-rays and other scans in their children.

"Tell them that CT scans save children's lives, and that it would be tragic if a parent refused a critically needed exam just because of a concern about radiation," said Bradford W. Betz, M.D., division chief, radiology, Helen DeVos Children's Hospital and a radiologist with Advanced Radiology Services, PC. "From the beginning, our goal has always been to keep the radiation dose to children as low as possible," he said.

Last year, the radiology department at Helen DeVos Children's Hospital moved a step closer to meeting that goal when it created an ALARA committee (ALARA stands for "As Low As Reasonably Achievable") to monitor the radiation dose in pediatric radiology to ensure the use of the safest possible amount; develop new ways to reduce the dose even further; and educate healthcare professionals, patients and families about the importance of keeping the dose as low as possible. "To my knowledge, we are the first ALARA committee in the country that is a collaboration of an entire pediatric radiology department," said Dr. Betz.

Low radiation is particularly important in children, Dr. Betz said, because still-developing tissue make children 5% to 10% more sensitive to the long-term effects of radiation, particularly in the breast and thyroid gland. And it is particularly important with CT scans, which use radiation doses up to 100 times the dose of a similar x-ray. This makes alternatives to CT scans, such as ultrasound or MRI, even more important.

Eventually, Dr. Betz said, he would like to see the vendors of radiology equipment provide dose information about patients that could be downloaded and tracked. "Then we can review that information and catch those children who have had a lot of scans."

To learn more about pediatric radiation, visit the Image Gently Web site at www.pedrad.org/associations/5364/ig/.

Just the Facts

The pediatric radiology department at Helen DeVos Children's Hospital has adopted the ALARA—As Low As Reasonably Achievable—approach to pediatric x-rays, including CT scans, to ensure the lowest-possible dose of radiation that will still provide readable images.

When the Going Gets Tough: Managing Pediatric Constipation

Constipation is one of the most common complaints seen in pediatric practices and no, it's not your imagination—you really are seeing more of it. A recent analysis from the National Ambulatory Medical Care Survey (NAMCS) found the rate of ambulatory visits for constipation in children 0-14 years of age increased from 16.2 per 1,000 population during 1993-1996 to nearly 40 per 1,000 population during 2001-2004. As a result patient visits to pediatricians for constipation have nearly doubled, from 12.8% of all visits during 1993-1996 to nearly 21% during 2001-2004.¹

Which begs the question: What is the best way to treat constipation in children?

Start by asking the right questions, said Deborah Cloney, M.D., a pediatric gastroenterologist with Helen DeVos Children's Hospital. "The complaint the child presents with may vary," she said. "It's not always large, hard, painful bowel movements." For instance, children might complain of abdominal pain or, in some cases, of diarrhea because stool has leaked around an impaction.

Thus, she said, when a child presents with a gastrointestinal complaint it is important to ask about the bowel movement itself. "How often are you having one? How big is it? How firm is it? Does it hurt?" And listen for clues, she said. "If they say they are only going every five days and have to flush the toilet twice, then you know that constipation is probably what's going on." A rectal exam is indicated, particularly for overweight children in whom it may be difficult to feel a fecal mass with abdominal palpation.

So what is normal for a child? Depends on the child, said Dr. Cloney. Most children pass a bowel movement somewhere between three and four times a day and once every three or four days. The key is determining the normal pattern *for that child*, and any significant deviation from that pattern.

Before referring for a GI consultation, she recommends the primary care physician try the following:

1. **Prescribe large doses of stool softeners.** The standard dose of stool softener often has no effect on a child with impacted bowels, said Dr. Cloney. "They need a 'cleanout' to flush out their system." She recommends a double dose (17 g bid) of polyethylene glycol (MiraLax, GlycoLax, etc) for two or three days until the child has a bowel movement. Adding mineral oil during the cleanout (1 ounce per year of age divided tid, maximum

9 ounces/day) can also help (suggest mixing it with yogurt, pudding or a milkshake to improve palatability). Once the child has a bowel movement, titrate down to the maintenance dose.

2. **Give the full maintenance dose.** Too often, parents try to reduce the dose on their own once their child is begins stooling. Then the constipation returns. Dr. Cloney reminds parents that the goal is to have pain free bowel movements at least every two to three days with stool that resembles "mashed potatoes."

3. **Continue the stool softener for three to six months.** "The child wasn't constipated for only two days," Dr. Cloney noted. Often, it has been weeks or even months. In toddlers, the pain associated with bowel movements quickly becomes a control issue. "If they recognize that a bowel movement hurts, they refuse to have one," said Dr. Cloney. "You've got to keep it soft long enough so they forget that it was painful." Another reason to continue the medication for months is that a child who has been chronically constipated may have developed a dilated rectum and colon, which makes it easier to hold stool. This may require weeks or even months to normalize. Weaning the stool softener slowly (over four to eight weeks) is appropriate.

4. **Support the family.** "We provide the parents with guidelines to adjust the stool softener if it's not working and ask them to call if the child gets diarrhea or isn't improving," Dr. Cloney said. She typically schedules a follow-up visit one month after beginning the cleanout regimen or in three months if the child was less constipated. "We want to make sure they're well-regulated before we start chipping away on the stool softener," she said.

She also provides nutritional information on the importance of a high-fiber diet and fluid, and, if the family needs additional support, refers to a dietician. It is also important that parents learn the importance of regular toilet time and train the child to sit on the toilet twice a day for 5 minutes at a time. If the child has any encopresis, it is important to stress the importance of good hygiene, including baths, to reduce the risk of skin breakdown.

So when should pediatricians refer? "Someone who has vomiting along with constipation, an apparent obstruction, or a very early history of constipation, such as a newborn who has not passed meconium, should be referred," said Dr. Cloney. Other issues that warrant referral include genital abnormalities,

suspicion of Hirschsprung's disease, and failure-to-thrive comorbid with constipation. Or, she said, when an attempted cleanout and aggressive use of stool softener hasn't worked and "you feel you've hit the wall!"

To refer to the gastroenterology clinic at Helen DeVos Children's Hospital, call (616) 391-8882 or fax to (616) 391-8896.

Just the Facts

- Constipation is one of the most common complaints seen in pediatric practices.
- Pediatricians should aggressively treat constipation with large doses of stool softeners, eventually titrating down to a maintenance dose after stooling begins and continuing it for three to six months.
- Refer for recalcitrant constipation or constipation comorbid with other conditions, including vomiting and failure-to-thrive, and for constipation in infants.

¹Shah ND, Chitkara DK, Locke GR, Meek PD, Talley NJ. Ambulatory Care for Constipation in the United States, 1993-2004. *Am J Gastroenterol.* 2008 Jun 12. [Epub ahead of print]



Sports-related Injuries in the Pediatric Office

Whether from summer camps or the start of practices for fall sports, this is the time of year pediatricians see a plethora of sports-related injuries. The most common one?

"Ankle sprains," says Jeffrey A. Cassidy, M.D., a pediatric orthopedic surgeon at Helen DeVos Children's Hospital. Specifically, lateral ankle sprain, one of the most common athletic injuries seen in children and adolescents.¹ If it's a child's first or even second ankle sprain, then certainly the primary care physician can manage it with traditional RICE treatment:

- R**est for the first 24 to 48 hours
- I**ce for the first 48 hours, 20 minutes at a time
- C**ompression early in the treatment phase
- E**levation higher than the heart, including at night

However, the recurrence rate of lateral ankle sprains is high, up to 80% in some studies,² with 75% of ankle sprains in professional soccer players attributable to previous sprains.³ The reason for the high recurrence remains unclear, but could be related to proprioception and muscle strength deficits. Thus, after the second sprain it's a good idea to refer to an orthopedic specialist for evaluation.

While it is uncommon for kids to need orthopedic surgery, said Dr. Cassidy, physical therapy, particularly exercises to strengthen the perineal muscles and provide proprioceptive training to improve the child's ability accommodate sudden movements around the ankle, can help.

Even after just one sprain, he noted, clinicians should consider recommending ankle braces or taping the ankle during sports activities.

Beyond ankle sprains, however, the community pediatrician has an important role to play in helping parents and their children become aware of the risk of sports-related injuries and recommendations from the American Academy of Pediatrics (AAP) regarding organized sports for children, burnout, overuse injuries and overtraining, and intensive training and sports specialization in children.

"If a child is experiencing injuries over and over again, you have to start looking at their level of participation in sports," said Dr. Cassidy. The days when children switched between sports and even took entire seasons off are past; today, even elementary-aged children are likely to focus on one sport throughout the year, resulting in a high rate of overuse injuries.⁴

The AAP recommends:⁵

- Children should not be pushed beyond their abilities and interests in a sport.
- Children should not specialize in a single sport before adolescence.
- Pediatricians should work with parents to ensure that the child athlete is coached by individuals knowledgeable about proper training, techniques, equipment, and children's physical and emotional characteristics.
- Pediatricians should aim to prevent and treat overuse injuries early. Children should never be encouraged to "work through" these injuries.
- Pediatricians should regularly monitor the condition of children involved in intensive sports and educate the athlete, family and coach about preventing and recognizing heat injuries.
- Children involved in intensive sports need ongoing assessment of their nutritional intake.

Referring to the orthopedic clinic at Helen DeVos

For more information or to refer a patient to the Helen DeVos Children's Hospital Orthopaedics Team, call (616) 391-9814 or fax a new appointment request form to (616) 486-0112. Clinical data needed for all referrals include: patient demographics, recent progress report or ER notes, growth chart, x-ray, MRI ultrasound and/or CT reports (if applicable) and list of current medications.

A Closer Look: The Youth Soccer Player

One of the first comprehensive reviews of youth soccer injuries in the United States was published in February 2007 in the *American Journal of Sports Medicine*. It evaluated the 1.6 million pediatric soccer-related injuries that presented to US emergency departments between 1990 and 2003.⁶ Among the findings:

- The most common injuries occurred in the wrist/ finger/hand (20.3%), ankle (18.2%), and knee (11.4%).
- The most common diagnoses were sprain/strain (35.9%), contusion/abrasion (24.1%), and fracture (23.2%).
- Girls sustained more ankle and knee injuries than boys and were more likely to have sprains or strains than boys.
- Concussion was the most common injury in players 15 to 18 years old.

- Younger players (up to age 9) were more likely to be hospitalized for injuries than older players, and children ages 2 to 4 were more likely to experience face and head/neck injuries than older children.

Just the Facts

Pediatricians need to regularly assess their patients involved intensively in one or more sports; educate families about the risks of overuse injuries; and learn to recognize overuse injuries early.

¹Willems T, Witvrouw E, Verstuyft J, Vaes P, De Clercq D. Proprioception and Muscle Strength in Subjects With a History of Ankle Sprains and Chronic Instability. *J Athl Train*. 2002 Dec;37(4):487-493.

²Hertel J. Functional instability following lateral ankle sprain. *Sports Med*. May 2000;29(5):361-71.

³Ekstrand J, Gillquist J. The avoidability of soccer injuries. *Int J Sports Med*. May 1983;4(2):124-8.

⁴Intensive training and sports specialization in young athletes. American Academy of Pediatrics. Committee on Sports Medicine and Fitness. *Pediatrics*. 2000 Jul;106(1 Pt 1):154-7.

⁵Leininger RE, Knox CL, Comstock RD. Epidemiology of 1.6 million pediatric soccer-related injuries presenting to US emergency departments from 1990 to 2003. *Am J Sports Med*. 2007 Feb;35(2):288-93.

Introducing... the 3T MRI

Just the Facts

- New 3T MRI available at Butterworth Hospital/Helen DeVos Children's Hospital
- Doubles the strength of existing MRI
- Faster imaging with significantly greater detail
- May be used for diagnosing brain disorders, mapping brain tumors, and identifying bone and joint abnormalities

The introduction of Spectrum Health's first 3T (Tesla) MRI doubles the strength of the magnetic field, offering an entirely new level of adult and pediatric images to patients and clinicians throughout the region. "The anatomic detail with the 3T is amazing," said Bradford W. Betz, M.D., division chief of pediatric radiology at Helen DeVos Children's Hospital, and a radiologist with Advanced Radiology Services, PC. That power translates into a greater ability to spot abnormalities, he said, even in children whose initial physical and radiological exams appeared normal.

The new MRI is currently available at Butterworth Hospital. A second will be online this fall. The impact on children is particularly significant, said Dr. Betz. Scans will be faster, enabling more children to avoid sedation, while the increased power enables scans that evaluate brain function as well as anatomy. "By understanding how the brain is organized and developed, we can create a roadmap of the areas of the brain responsible for motor function, language, etc., providing neurosurgeons with more accurate information when children need surgery," he said.

The new MRI will also be useful for helping to diagnose brain disorders as well as determining whether abnormalities might be tumors, he said. But don't forget musculoskeletal imaging. "It's just gorgeous," Dr. Betz said. The enhanced imaging means that radiologists will be able to identify subtle abnormalities that may be difficult to identify with 1.5T MRI, such as cartilage tears and congenital joint abnormalities.

The new scan may also eliminate the need for biopsy in some cases; reduce the need for re-imaging because of patient or organ movement; and provide a critical new level of detail for pre-surgical planning. Not every exam benefits from 3T technology, however. "It is important that radiologists select the MRI scanner best suited for the needs of each patient," said Dr. Betz.

To refer a patient for the 3T MRI scan, contact radiology scheduling at (616) 391-1810. For questions about MRI, Dr. Betz can be reached in the radiology department at (616) 391-1812.

⁶Brenner DJ, Hall EJ. Computed tomography--an increasing source of radiation exposure. *N Engl J Med*. 2007 Nov 29;357(22):2277-84. Review.



Back to School Vaccines for the Older Set

Telling a preadolescent or adolescent they need a shot is like telling them they need to give up their cell phone. Ok, maybe not quite so bad. Still, pitching vaccines to teens and preteens is not an easy sell, admits Lisa Lowery, M.D., an adolescent medicine specialist at Helen DeVos Children's Hospital. For one thing, you have to get the kid into the office. "It's not uncommon for a lot of teens to not have been seen since they were 11 or 12," said Dr. Lowery.

Yet the Centers for Disease Control and Prevention recommends three vaccines beginning around age 11 or 12: tetanus-diphtheria-acellular pertussis (Tdap), meningococcal vaccine, and, for girls, the human papillomavirus (HPV) vaccine (see article on page 00). In addition, a second "catch-up" varicella shot is recommended for adolescents who previously received one dose.¹

To get teens in for their shots, Dr. Lowery suggests discussing it with parents when they bring in younger siblings; making pamphlets about the vaccines available in the waiting and examining rooms; and reviewing the immunization record when the teen is seen for a medical problem.

Clinical Pearl

Overcoming Barriers to the HPV Vaccine

Educating parents about the HPV vaccine and its link with cervical cancer could improve the rate of vaccination in preteen and teenaged girls.

Much of the American public has little knowledge about the human papillomavirus (HPV) and its links with abnormal Pap smears and cervical cancer, despite the introduction of a vaccine two years ago (Gardasil) to prevent infection.² That makes it challenging for pediatricians and family practitioners to convince parents of the importance of vaccinating their preadolescent and adolescent daughters against the virus.

Lisa Lowery, M.D., an adolescent medicine specialist at Helen DeVos Children's Hospital, offered her responses to the barriers parents often raise about the HPV vaccine:

"My daughter is not sexually active so (the vaccine) is not necessary." Dr. Lowery stresses the preventive aspect of the vaccine and the need to give it *before* a girl

becomes sexually active. She also stresses the fact that immunogenicity response in preadolescents is slightly higher than in adolescents or adults.

"It's too new; let's wait a while to make sure it's safe." Dr. Lowery informs parents that more than 12 million doses of the vaccine have been given and that no significant adverse effects have been reported.

"She's going to wait until she gets married to have sex, so she won't need it." Dr. Lowery acknowledges the importance of waiting and abstinence, but stresses the importance of the fact that Gardasil is a prophylactic vaccine.

Studies also suggest that educating parents about the HPV vaccine and its link to cervical cancer and providing a personal recommendation as a physician influence parental acceptance of the vaccine.³ ⁴Dr. Lowery also found that mothers' or another family member's own experiences with an abnormal Pap provide a good incentive. "They say, 'I don't want my daughter to have to go through that,'" she said.

¹Vaccinations for Teenagers. Centers for Disease Control and Prevention. Available at: <http://www.cdc.gov/vaccines/recs/schedules/teen-schedule.htm>. Accessed June 24, 2008.

²Zimet GD. Understanding and overcoming barriers to human papillomavirus vaccine acceptance. *Curr Opin Obstet Gynecol.* 2006 Feb;18 Suppl 1:23-8.

³Gonik B. Strategies for fostering HPV vaccine acceptance. *Infect Dis Obstet Gynecol.* 2006;2006 Suppl:36797.

⁴Dempsey AF, Zimet GD, Davis RL, Koutsky L. Factors that are associated with parental acceptance of human papillomavirus vaccines: a randomized intervention study of written information about HPV. *Pediatrics.* 2006 May;117(5):1486-93.

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In the April 2008 Pediatric Perspectives Presidents Message, Tim Bunchman, M.D. and Gina Marie Barletta, M.D. were incorrectly referred to as neurologists. Both are nephrologists working with Dr. James Birmingham to develop a vasculitis clinic to treat children with autoimmune diseases and renal involvement. Our sincere apologies for the identification error.