

# physician's update

**February 2008**

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George W. Holcomb III, MD

## SURGERY CONTINUES GROWTH TREND

The Department of Surgery is a very active part of Children's Mercy Hospitals and Clinics' commitment to the care of infants and children in the Kansas City area and the surrounding region, and the number of operations performed annually continues to increase, from 7,864 in 1996 to 15,636 in fiscal year 2007.

The Section of General Surgery and Urology is nationally known for its emphasis and expertise in minimally invasive surgery; new, high-technology operating rooms allow many complex operations to be performed in this fashion. For the last several years, there has been a national emphasis on outcomes research and our general surgeons and urologists are leading this effort among the pediatric hospitals. Shawn St. Peter, MD, joined the Section of General Surgery a year ago and currently leads the clinical research enterprise in prospective trials, and Romano DeMarco, MD, has recently joined John Patrick Murphy, MD, and John Gatti, MD, in urological surgery.



The Section of Orthopaedics is now offering clinics five days a week at Children's Mercy Hospital and Children's Mercy South, and three days a week at Children's Mercy Northland. In addition, Kevin Latz, MD, and Donna Pacicca, MD, are developing an excellent pediatric sports medicine program, and Nigel Price, MD, and Rick Schwend, MD, are expanding services for patients with scoliosis and other spine anomalies. A pediatric orthopaedic nurse practitioner is also available to help evaluate non-urgent orthopaedic concerns faster and more efficiently than in the past. Finally, Christine Cheng, MD, has joined the orthopaedic faculty and has a pediatric hand clinic one day a week at the downtown location.

Scott Olitsky, MD, Section Chief of Ophthalmology, has initiated a multi-hospital cooperative for the Children's Mercy ophthalmologists to screen most of the premature infants in Kansas City for possible retinopathy of prematurity (ROP). In addition, the section is developing a Midwest Regional Treatment Center for ROP surgery. Optical shops will be opened soon at all three Children's Mercy clinic sites for improved service and care. Finally, the Children's Mercy Pediatric Ophthalmology Fellowship Program is in its third year and continues to attract outstanding ophthalmology residents who wish to specialize in pediatric conditions.

As always, please do not hesitate to contact me or other Children's Mercy surgeons with any questions or concerns. Our goal is to provide the best and most up-to-date care for your patients and their families.

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GEORGE W. HOLCOMB, III, MD, MBA  
 SURGEON-IN-CHIEF  
 CHILDREN'S MERCY HOSPITALS AND CLINICS  
 (816) 234-3575

## NEWS BRIEFS

### Child Health Library

Children's Mercy has greatly expanded its online "Child Health Library" with the addition of more than 1,200 new child health and safety topics from McKesson (the same database used by our Contact Center and Pediatric Care Center).

Care Cards, Med Cards, Teen Cards and other resources which have been used by physician offices are still available as a separate database and are still able to be customized with your practice's name on them. The new "Child Health Library" Web site also includes podcasts, video and audio interviews with Children's Mercy faculty physicians, the Safe & Sound video stories and newsletters and much more.

To see the new site, go to [www.childrensmercy.org](http://www.childrensmercy.org) and click on "Your Child's Health." If you have any questions about this new resource for parents, just contact Physician Services at (816) 234-1641 or [mmcmillan@cmh.edu](mailto:mmcmillan@cmh.edu).

### Resource Guide Update

Children's Mercy is in the final stages of preparing the 2008 Children's Mercy Resource Guide. Our goal is to have these ready for distribution by the end of March. Copies of the Resource Guide will be mailed to your office. A card will be enclosed to allow you to request additional copies. Up-to-date information on

Children's Mercy physicians and services can always be found on our Web site at [www.childrensmercy.org](http://www.childrensmercy.org). For more information, contact Michelle McMillan, Physician Services Director, (816) 234-1641 or [mmcmillan@cmh.edu](mailto:mmcmillan@cmh.edu).

### Upcoming Conferences

#### Fourth Annual Jerry Blouin Memorial Symposium on Congenital Heart Disease

April 12, 2008

7 a.m. to 3:30 p.m.

Overland Park Convention Center  
Overland Park, KS

#### Third Annual Springfield Pediatric Specialty Care Update

April 19, 2008

7:30 a.m. to 1 p.m.

University Plaza Hotel  
Springfield, MO

#### Second Annual Transport Conference – Kids n' Kopters

June 4-7, 2008

Kansas City, MO

For more information on these conferences, visit [www.childrensmercy.org/physicians](http://www.childrensmercy.org/physicians) and select CME calendar.

## NEW FACULTY

### Sergio A. Facchini, MD

**Child Neurologist**  
(816) 234-3090

**MD Degree:** Federal University of Juiz de Fora, Juiz de Fora, Brazil, 1968

**Residency:** Pediatrics, University of Tennessee College of Medicine, Memphis, TN; Neurology, University of Tennessee College of Medicine, Memphis, TN

**Fellowship:** Child Neurology, University of Tennessee College of Medicine, Memphis, TN

**Certifications:** Psychiatry and Neurology (Special Qualification in Child Neurology) 1996



### Lien Russell, MD

**Assistant Professor of Pediatrics**  
(816) 234-3080

**MD Degree:** University of Missouri-Kansas City School of Medicine, Kansas City, MO, 1998

**Residency:** Pediatrics, University of Tennessee Health Science Center; Le Bonheur Children's Medical Center, Memphis, TN

**Certifications:** Pediatrics, 2001



## CLINICAL UPDATE: JIA

Juvenile Idiopathic Arthritis (JIA) is one of the most common chronic diseases of childhood and is an important cause of morbidity and disability in children. It affects an estimated 300,000 children in the United States.

JIA is characterized by idiopathic peripheral arthritis with an immuno-inflammatory pathogenesis, possibly triggered by an external antigen. Although the terminology has changed over the years, the general term JIA encompasses several subtypes. The most recent classification criteria include systemic onset JIA, polyarticular (rheumatoid factor positive) JIA, polyarticular (rheumatoid factor negative) JIA, oligoarticular JIA, oligoarticular (extended) JIA, psoriatic arthritis, enthesitis associated JIA, and other.

Although classifying patients into each subgroup is detailed and at some times quite difficult, the main component of JIA remains arthritis. Arthritis is characterized by swelling within, rather than surrounding the joint. This swelling results in pain with range of motion or decreased range of motion. A position of comfort for a swollen joint is in the flexed position, therefore flexion contractures commonly result in untreated arthritis.

Typically this type of arthritis results in swollen and warm, but not red or exquisitely tender joints. It tends to present subacutely, with subtle changes such as a morning limp that resolves throughout the day. In order to diagnose a patient with chronic arthritis, the arthritis must be present for at least six weeks, otherwise a postinfectious or reactive etiology may still be the cause.

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The goal of therapy for JIA is to decrease inflammation within the joint, therefore alleviating pain and swelling, and decreasing the chance for long term damage to the joints. In the rare case of erosive arthritis, commonly seen in RF+ polyarticular disease, the goal is to stop or even reverse erosions and damage within the joint.

Common medications used to treat arthritis include: nonsteroidal anti-inflammatory drugs (NSAIDs) such as naprosyn or ibuprofen; disease modifying anti-rheumatic drugs (DMARDs) such as methotrexate; systemic glucocorticoids; and biologic agents such as anti-tumor necrosis factor- $\alpha$  (TNF- $\alpha$ ) medications, such as etanercept, infliximab, or adalimumab. DMARDs, biologics, and systemic corticosteroids will all put patients at greater risk for infection and may mask some of the typical signs and symptoms of infection. Live vaccines should also be avoided when taking these medications.

The goal for the treatment of JIA is for the patients to lead a normal life now and have full use and function of their joints in the future. With early detection and the availability of better medications we are better now at accomplishing that goal than ever.

MARA BECKER, MD  
CHILDREN'S MERCY RHEUMATOLOGY SECTION  
ASSISTANT PROFESSOR OF PEDIATRICS,  
UMKC SCHOOL OF MEDICINE

## CASE OF THE QUARTER

A four-month-old previously healthy female presented to her PCP with wheezing, cough, and weak cry. She was started on Omnicef and albuterol with brief improvement in her symptoms. However, her cough continued at several follow-up visits. Despite continuing albuterol, adding Pulmicort, and changing antibiotics to Biaxin, her symptoms worsened over one month so she was admitted for further evaluation.

On exam, she was afebrile, tachypneic and tachycardic; her O<sub>2</sub> saturation was 96 percent on room air. Other significant exam findings included: ill appearance with grunting respirations, moderate retractions, and no breath sounds audible over the left lower lobe; heart with gallop rhythm, grade II/VI murmur, weak distal pulses; and liver 2 cm below costal margin.

Labwork revealed normal CBC, electrolytes, and LFTs. Chest x-ray showed cardiomegaly and ECG showed ST segment elevation in the lateral leads. Cardiac enzymes were elevated. On echocardiogram her left ventricle was enlarged and dilated with poor function; no left coronary artery was seen arising from the aorta. Cardiac catheterization confirmed the echocardiogram findings of anomalous left coronary artery arising from the pulmonary artery.

She underwent a Takeushi reconstruction (creation of an aortopulmonary window directing aortic blood to the anomalous coronary artery). Post-operatively she did well, with gradual resolution of her CHF.

Anomalous origin of the left coronary artery, also known as Bland-White-Garland syndrome, is a rare disease, accounting for less than 1 percent of congenital heart disease. It occurs when the conotruncus divides abnormally, leading to origination of the left coronary artery from the pulmonary artery instead of the aorta.

Patients typically develop symptoms (tachypnea, tachycardia, poor feeding, irritability, and diaphoresis) around 2-3 months of age as the pulmonary and right ventricular pressures drop. Ultimately, left ventricular insufficiency and infarction occur due to coronary steal.

Work-up includes chest x-ray, ECG, echocardiogram, cardiac enzymes, and cardiac catheterization. After diagnosis, surgical repair is necessary, and two options are available: the Takeushi repair and the "button procedure" (transfer of the coronary artery into the aortic root).

Although anomalous left coronary artery is a rare cardiac defect, it is an important diagnosis to include in a thorough differential diagnosis. Bronchiolitis, at this time of year (winter), is in the forefront of the minds of pediatricians; however, it is important to consider less common diagnoses as well.

KRISTI WILLIAMS, MD, CO-CHIEF RESIDENT, PEDIATRICS  
TARA ANDERSEN, DO, CO-CHIEF RESIDENT, PEDIATRICS

# REMINDER: ANTENATAL REFERRAL SERVICE

The Antenatal Referral Service is for parents who are expecting a baby with a fetal anomaly who is likely to require intensive care at Children's Mercy.

Contact with the Antenatal Referral Service allows parents to meet with a neonatologist, pediatric subspecialist, or surgeon as appropriate. Parents can also tour the Intensive Care Nursery at Children's Mercy prior to delivery of the child.

For appointments, contact Barb Haney, RNC, MSN, CPNP, coordinator of the Antenatal Referral Service. She can be reached toll free at 1-866-281-8480, by fax at 816-855-1909, or via e-mail at [bhaney@cmh.edu](mailto:bhaney@cmh.edu).



## HERE TO HELP YOU

The Children's Mercy Physician Services staff is available to answer questions from physicians and their staff on how to access Children's Mercy Hospitals and Clinics services.

The Physician Services staff can assist you with questions or concerns about communication with our physicians, CME opportunities, outreach clinics, patient information or a clinic report, as well as provide helpful materials such as the Resource Guide, Quick Reference Guide and maps.

For assistance, please call Michelle McMillan, Physician Services Director, (816) 234-1641, or Nancy Baker, Administrative Assistant, (816) 234-1642.



Physician's Update is produced monthly by Community Relations and Physician Services. For more information, contact:

SHAWN ARNI  
(816) 346-1371  
[SARNI@CMH.EDU](mailto:SARNI@CMH.EDU)

**VISIT THE CHILDREN'S MERCY WEB SITE: [WWW.CHILDRENSMERCY.ORG](http://WWW.CHILDRENSMERCY.ORG)**

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