

Surgical Researcher Receives Kreamer Award

George Gittes, MD, director of Surgical Research, has been named the 2005 recipient of the Kreamer Pediatric Research Excellence Award. Dr. Gittes has been a member of the Children's Mercy medical staff for five years and holds the Thomas M. Holder/Keith W. Ashcraft Chair in Pediatric Surgical Research. His research focuses on identifying various signaling mechanisms in the developing pancreas, with a goal of curing various endocrine abnormalities related to the pancreas, including diabetes.



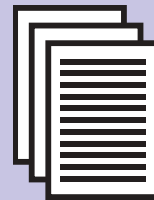
George Gittes, MD, is the 2005 recipient of the Kreamer Pediatric Research Excellence Award.

Dr. Gittes has more than 180 publications in peer-reviewed journals, with 40 of them published since his arrival at Children's Mercy. He is currently the principal investigator on two NIH grants and a grant from the Juvenile Diabetes Research Foundation. He also serves as president of the Society of University Surgeons, the premier academic surgical organization in the world. He received his medical degree from Harvard Medical School, completed his surgical residency at the University of California in San Francisco and his fellowship in pediatric surgery at Children's Mercy.

The Kreamer Pediatric Research Excellence Award has been presented to a Children's Mercy researcher every year since 1993 in recognition of continuing excellence in research. The award was created in memory of the philanthropic and civic leadership of John and Marion Kreamer, who were long-time friends and supporters of Children's Mercy Hospital.

Referral Notes

When referring a patient to a Children's Mercy specialist, please be sure to send all relevant lab results and radiology films with the patient. Please also fax appropriate patient history information. This will assist us in providing efficient and cost-effective care.



Physician's Update is produced monthly by Community Relations and Physician Services. For more information, contact Shawn Arni, (816) 346-1371 or e-mail to sarni@cmh.edu.

Visit the Children's Mercy Web site: www.childrens-mercy.org

Physician's Update

April 2005

Surgical Transformations

While it may not qualify for "Extreme Makeover", surgical services at Children's Mercy have received a new look that is eye-catching and functional.

Patient families will immediately notice the difference in the Surgical Waiting Area, which has relocated from the second floor to the first floor of the hospital. In addition to expanded seating, the new waiting room offers amenities and convenience for parents including private consultation rooms, a lactation room, a children's play area that features a big screen projection television, and a break area for drinks and snacks. The room is located adjacent to the hospital vending area, Snack Shop and Gift Shop.



New Surgery Waiting Area

"The new waiting area not only helps make families more comfortable while their child is in surgery, but provides more privacy when meeting with the surgeon and discussing their child's case," says Susan Mecklenburg, RN, director of Surgical Services. "The changes should lead to even higher patient and family satisfaction."

The transformation is not just cosmetic, though. The hospital has also invested in physical improvements with the addition of two new endoscopic surgery suites.

The new surgical suites, equipped with state-of-the-art monitors and equipment consoles that hang from the ceiling boom, provide for more operating efficiency by keeping equipment off floors and carts. New digital monitors provide much greater visual clarity for surgeons. Telecommunication capabilities allow for surgeries to be viewed all over the world as part of the hospital's teaching mission. The new suites were funded by proceeds from the Children's Mercy Golf Classic.

"We are not the first ones to have this equipment," says George "Whit" Holcomb III, MD, surgeon-in-chief, director of the Center for Minimally Invasive Surgery, and professor of surgery at the University of Missouri-Kansas City School of Medicine. "But, when combined with our knowledge and expertise, these suites further strengthen our position as a worldwide leader in minimally invasive pediatric surgery."

Children's Mercy ranks among the top three in the country in number of pediatric laparoscopic and thorascopic surgeries, according to Dr. Holcomb. Children's Mercy performed 15,426 surgeries in 2004, with 11,531 performed as outpatient procedures. Approximately 30 percent of all surgical procedures are now performed by minimally invasive methods or with endoscopic assistance.

"We've been at the forefront of a steadily rising volume of these procedures," says Dr. Holcomb. "Many of these surgical procedures can be performed using laparoscopy or thoracoscopy. That wasn't the case 10 years ago."

For more information on pediatric surgical services at Children's Mercy, call (816) 234-3578.



New Surgical Suite

Children's Mercy is an equal opportunity/affirmative action employer and a United Way Agency.

Return Service Requested

www.childrens-mercy.org
Kansas City, Missouri 64108-4698

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News Briefs

Pre-registration For Patients

Pre-registration for appointments is now available through the Children's Mercy Internet site. Please encourage your parents/patients to use this secure and convenient way to pre-register. By doing so, it will ensure a smooth and efficient registration process at the time of their appointment. Pre-registration is available for new patients and for patients whose information has changed since their previous appointment at Children's Mercy.

To pre-register:

- Access Internet site at www.childrens-mercy.org
- Select the Parents & Children option
- Select the Pre-Registration option located on the left side of the page
- Select location of facility and clinic where patient is being seen
- Fill out form
- Click on the Submit button at the bottom of the page. Submit only once.

Case of the Quarter

A 26-month-old male had a two-week history of increasing tiredness, decreased activity, and looked increasingly pale. He had been otherwise well. He did not have a history of illness, vomiting or diarrhea. His mother thought that he had been somewhat irritable as well.

On exam, he was pale and somewhat listless. He had a III/VI early systolic murmur. The rest of the exam was normal.

Laboratory studies revealed a normocytic anemia with a low red blood cell count. The reticulocyte count was low. The peripheral smear showed normal red blood cell morphology. Thyroid studies were normal.

This patient was diagnosed with Transient Erythroblastopenia of Childhood (TEC). Because he was symptomatically anemic, he was transfused with packed red blood cells. After he stabilized, he was discharged to home with weekly clinic visits to monitor his complete blood count and reticulocyte count.

TEC is a self-limited suppression of red cell production in a healthy child. The pathophys-

The information is entered onto the patient's account shortly after it is received in Admissions. Please contact Admissions at (816) 234-3567 if you have any questions.

Kudos And Congrats

Children's Mercy Emergency Medicine staff authored eight articles in the December 2004 issue of Clinical Pediatric Emergency Medicine. **Jane Knapp, MD**, was guest editor for the issue which focused on Emerging Concepts in Pediatric Emergency Medicine.

The Joint Commission for Accreditation of Health Care Organizations (JCAHO) has given Children's Mercy Hospitals and Clinics a perfect score for meeting all of the commission's quality and safety standards. We received no requirements for improvement from the surveyors who spent five days here reviewing clinical processes, interviewing staff and following patients through their stay.

iology is unknown, but hypothetically, there may be a possible viral etiology. Familial TEC has been rarely reported. This may suggest a combination of genetic and environmental factors in the development of TEC. The usual age of diagnosis is around 2 years of age.

Males do develop TEC more frequently than females. In the diagnosis of TEC, it must be a normocytic, normochromic anemia with the red blood cell line being the only cell line affected. Therapy includes initial admission with observation for complications of severe anemia. Transfusion with packed red blood cells is only recommended if there is evidence of cardiovascular compromise. There is no role indicated for prednisone or iron supplementation. All children usually recover within one to two months after diagnosis. Elevation of reticulocyte count is the first sign of recovery. Reoccurrence is rare.

*J. Bryan Wohlwend, MD and
Megan R. Loeb, MD
Co-Chief Residents, Pediatrics*

MIS Moves Into Mainstream

Without a doubt, the arena of minimally invasive surgery represents the cutting edge in the field of pediatric surgery today. In the early 1990's, many pediatric surgeons were slow to incorporate minimally invasive surgery in their practices. However, today, most pediatric surgeons utilize minimally invasive approaches to some degree.

In 2000, Children's Mercy Hospital developed the Center for Minimally Invasive Surgery to incorporate a number of different disciplines into this field. Today, minimally invasive surgical procedures are commonly applied to surgical diseases in the chest (thoracoscopy) and abdomen (laparoscopy). The advantages of a minimally invasive approach center on reduced discomfort, which leads to a reduced need for nar-

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cotic use which, in turn, leads to reduced hospitalization. Thus, the patients are able to resume their regular activity sooner (whether it is work, school, or play). Finally, although the major reason for using this approach is not cosmesis, there is a definite cosmetic advantage to this approach. A newly appreciated advantage is a markedly reduced incidence of postoperative intestinal obstruction in the abdomen when comparing laparoscopic versus open operations.

At Children's Mercy Hospital, commonly performed laparoscopic proce-

dures include fundoplication, cholecystectomy, appendectomy, pyloromyotomy, and splenectomy. In addition, the minimally invasive approach for correction of Hirschsprung's disease is also being utilized frequently. In appropriate patients, with this approach, a colostomy is not performed.

In the chest, a plethora of diseases are amenable to a thoracoscopic approach including wedge resection of an isolated nodule, ligation of blebs causing spontaneous pneumothoraces, drainage and decortication for empyema, lung and mediastinal mass biopsy, and, in selected

newborns, even repair of esophageal atresia and distal tracheoesophageal fistula.

With the opening of two state-of-the-art operating rooms in March 2005, patients in this region will be able to undergo a minimally invasive surgical procedure with the most advanced technology. In addition, for teaching purposes, Children's Mercy Hospital will have the capability of televising these operations anywhere in the world. Should questions arise about these operations or this technology, please do not hesitate to contact one of the surgeons involved in the Center.

*George W. Holcomb, III, MD, MBA
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Director, Center for
Minimally Invasive Surgery*



Minimally invasive surgery is becoming increasingly more common for pediatric patients.

New Doctor

Brenda Rogers, MD
General Pediatrics
Assistant Professor of Pediatrics, UMKC
(816) 234-3898

Medical School: University of Missouri-Kansas City School of Medicine, Kansas City, MO, 1990
Residency: Internal Medicine/Pediatrics, Creighton University, Omaha, NE; Internal Medicine/Pediatrics, University of Missouri-Kansas City, Kansas City, MO
Certification: Pediatrics, 1994, 2001; Internal Medicine, 1995

