

Physician's Update

May 2005

Is Mandatory Screening Needed?

Although they share a common goal of improving care for childhood vision problems, medical societies and vision advocacy groups don't see eye to eye on the need for mandatory vision screening.

The American Academy of Pediatrics and the American Association for Pediatric Ophthalmology and Strabismus support early vision screening and regular follow-up screenings, but they stop short of calling for mandatory screening.

"The current screening process works and there is no data to show that a mandatory evaluation is needed," says Scott Olitsky, MD, Ophthalmology section chief at Children's Mercy and associate professor of ophthalmology at the University of Missouri-Kansas City School of Medicine.

The Vision Council of America has called for mandatory screening of all pre-school age children, claiming that giving eye exams to all preschool-age children would detect, treat and cure significantly more cases of amblyopia than vision screenings.

The AAP recommends that vision screening should be performed at the earliest possible age and at regular intervals during childhood.

So why don't the AAP and AAPOS support mandatory screening of preschool children?

Mandatory screening presents a huge and potentially costly organizational challenge. Who will do the screenings? Who will coordinate results? Who will make sure follow-up care is provided? Who will measure outcomes? And who will pay for it all?

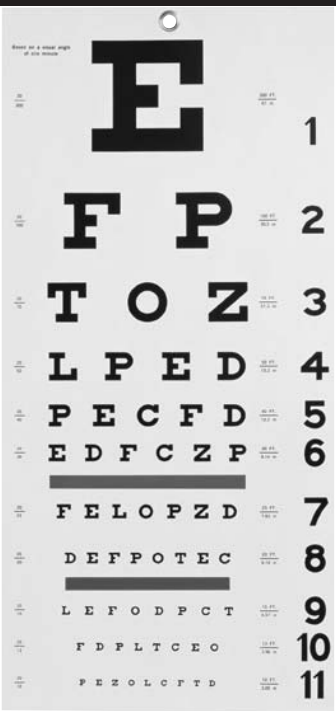
"Primary care physicians play an important role as the main point of entry to the health system," says Dr. Olitsky. "Mandatory exams can take the PCP out of the loop."

More study on the benefits and the development of an organizational structure to coordinate care are needed before a mandatory screening system can be considered locally, according to Dr. Olitsky.

Tennessee may be a model for how to implement a program. The Tennessee Lions Center uses photo screening to analyze every child tested in the state. All photos are sent to the Center to read, and follow-up care is coordinated.

"Photo screening can be an efficient and effective means of testing pre-school age children," says Dr. Olitsky. "It is incredibly cheap and very accurate, but it takes organization that we don't currently have in Missouri or Kansas."

Physicians who have children that require additional eye care can refer them to the Children's Mercy Ophthalmology clinic, (816) 234-3046. Appointments are often available the same day or within a few days of calling, and the primary care physician is kept involved in the child's ongoing care.



Children's Mercy
HOSPITALS & CLINICS
www.childrens-mercy.org

News Briefs

Radiology Reports

The listening line for radiology reports now requires a date of birth or a seven digit medical record number to be entered.

The first digit in new medical record numbers has now changed from a "0" to a "1". When prompted, please enter a seven digit medical record number. If you only enter six digits the system will not respond.

If the patient has one of the older six digit numbers please make sure to enter a leading "0".

If you have any questions, please call Radiology at (816) 234-3273.

Body Shop

We are now offering "The Body Shop for PARENTS", a six-week education program for parents with overweight children. This program is beneficial for parents wanting to improve the health of their families.

Sessions cover developmental issues, nutrition and exercise.

When: On-going classes throughout the year

Where: Children's Mercy South (Specialty Clinics Conference Room on the 2nd floor)

Cost: \$50

What: Healthy lifestyles, parenting and weight management

For more information or to enroll please contact the Nutrition Department at (816) 234-3468.

Online CME

Children's Mercy has ventured onto the information super highway with our first on-line CME opportunity!

The department of Health and Senior Services approached Children's Mercy to be CME provider for a course on lead poisoning. It was reviewed extensively by our own Catherine Simon, MD, and Gary Wasserman, DO.

You may access the CME program at: www.dhss.mo.gov/ChildhoodLead

Once there, you will choose: Healthcare Provider Continuing Medical Education. You will find content, a test, an evaluation, and a certificate. MD's and DO's will receive 1 hour of CME and other health care providers receive a certificate of completion.

Northland Access

Beginning May 17, the Missouri Department of Transportation will close the Paseo Bridge for up to seven months to complete much-needed maintenance activities. Interstate 35 and Interstate 29 cross the Paseo Bridge, so this may cause an inconvenience for Northland patients coming to Children's Mercy.

The Missouri Department of Transportation has established a Web site at www.paseobridge.org to provide alternate routes. Patients may also visit the Children's Mercy Web site at www.childrens-mercy.org or call (816) 983-6409 for directions.

New Doctor

Giang Dai Nguyen, MD

Hospitalist
(913) 696-8122

Medical Degree: University of Alabama School of Medicine, Birmingham, AL, 1998

Residency: Pediatrics, Medical College of Georgia, Augusta, GA

Fellowship: Pediatric Nephrology, Children's Mercy Hospital, Kansas City, MO, 2002-2003

Certification: Pediatrics, 2001



Update On Amblyopia Treatment

Treatment of amblyopia continues to make news.

Two years ago, the initial results from the Amblyopia Treatment Studies (ATS) were released. These studies are conducted in multiple centers throughout the United States and funded by the National Institutes of Health. The first studies looked at the efficacy of atropine penalization compared to occlusion therapy. Patients were randomized to receive atropine drops each day in their better seeing eye or patch six hours each day. The second ATS study compared two hours of patching a day versus six hours.

Results reported by the lay press indicated that both atropine and less patching were equally effective as more traditional patching. While patients treated with atropine and less patching did show significant improvement in their vision, a closer look at the data shows patients treated with greater amounts of patching achieved slightly better vision and did so in less time. Additionally, because the amount of actual patching performed was not rigorously monitored, the actual difference in the dose of treatment between these groups is not known.

There have been several additional ATS studies. Some of these have looked at using atropine less frequently, at the risk of amblyopia recurrence, and at the benefits of treating older children. The results of these studies have generated significant discussion not only among parents and patients but among pediatric ophthalmologists as well.

Full-time, or nearly full-time, occlusion continues to be the treatment of choice of many pediatric ophthalmologists. However, the use of atropine and less patching has gained considerable acceptance. Atropine penalization

may be especially helpful in children with moderate levels of amblyopia where compliance with patching has been an impediment to improvement. These studies have shown that more than one treatment option may exist for many patients. The best treatment for any single patient should be decided on an individual basis.

*Scott Olitsky, MD
Section Chief, Ophthalmology
Associate Professor of Ophthalmology,
UMKC*

In the pediatric population, tinea capitis is the principal dermatophyte infection, estimated to occur in approximately 1 in 20 school-aged children.



Hospitalist Update

It's Wheezin' Season

Unfortunately for our patients with asthma, it's the season to be wheezin' again. We are beginning to see the seasonal increase in admissions for status asthmaticus. For those of you who refer inpatients to the Hospitalist section, here is an update on our approach to the inpatient management of this most common pediatric chronic disease.

Our section has planned a series of progressive quality improvement projects aimed at improving the quality of the care provided when an inpatient stay is required. These quality monitors will focus on recommendations for managing asthma from the National Institutes of Health's National Asthma Education and Prevention Program Expert Panel Report: Guidelines for the Diagnosis and Management of Asthma¹ and updates thereof.

Our first objective has been to assure that all status asthmaticus patients are prescribed a written asthma action plan at the time of admission to facilitate education and appropriate step-wise treatment. Patients who already have an action plan prescribed by their primary care physician or an asthma specialist are exempted; however, we will review these patients' most recent symptom history and the current

action plan. If we consider a change to the action plan based on recent symptoms history, we will discuss potential changes with our community partners. During the four quarters since inception of this monitor, we have achieved nearly 100 percent compliance with the 355 admissions that have met inclusion criteria.

Future plans include a retrospective analysis of documentation at the time of admission to measure and improve the accuracy of our assessment of asthma severity and subsequent action plan prescribing.

As always, our goal is to not only provide the highest standard of evidence-proven care possible, but to do so in a cooperative effort with the primary care referring physicians. We welcome your input regarding all aspects of our inpatient management, including these asthma treatment initiatives.

*Brian Pate, MD
Section Chief, Hospitalists*

1. www.nlm.nih.gov/guidelines/asthma/index.htm

Hotline To Help

Community hospitals now have a hotline to Children's Mercy.

Children's Mercy has been working with hospitals throughout the region to install direct dial phones in emergency departments, nurseries and pediatric units.

The direct dial phone allows the medical professional to have direct access to the Transport Dispatch Center at Children's Mercy Hospital. The dispatcher then connects the caller to an neonatologist, pediatric intensivist or an ER physician, based on the patient's needs.

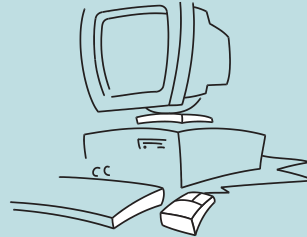
Using the phone is easy. All you have to do is pick up the phone and you are automatically connected.

The direct dial phones are provided at no charge and simply require an analog phone line with no special features. For more information or to inquire about placing a direct dial phone in your community hospital, contact Michelle McMillan, director of Physician Services, (816) 234-1641 or mmcmillan@cmh.edu.



Looking For Alumni

Children's Mercy is starting an alumni program for physicians who trained at the hospital as residents, fellows or medical students. If you know someone who trained at Children's Mercy but has moved out of the region, please ask him/her to contact Michelle McMillan, Physician Services director, (816) 234-1641 or e-mail to mmcmillan@cmh.edu.



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

Non-Profit Org.
U.S. Postage
PAID
Kansas City, MO
Permit 4301



PHYSICIAN SERVICES
2401 Gillham Road
Kansas City, Missouri 64108-4698
www.childrens-mercy.org

Return Service Requested

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

May 2005