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Pediatric News

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this issue

President's Letter

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President, AAP California, Chapter 2

Since the publication of our last newsletter, our Country has been rocked by two gut wrenching tragedies: the recent senseless bombing of spectators and competitors at the Boston Marathon; and the murder of 20 children and 6 teachers at Sandyhook Elementary School in Newtown, Connecticut. There is little that can be done to prevent the random and wanton violence of misguided individuals bent on terrorizing innocent citizens. But as sure as there are… immunizations to prevent communicable diseases, car and booster seats to prevent injuries from car accidents, helmets to prevent head injuries for cyclists, screening and interventions to reduce the risk of child abuse and neglect, newborn screening tests to diagnose and prevent disastrous outcomes from congenital defects and metabolic conditions, not to mention medications to reduce cardiac deaths and Type 2 diabetes in adults…there are proven strategies we can employ to reduce gun-related injuries and deaths in children and youth.

There are far too many gun-related deaths and injuries to go unnoticed or understated as they are in the current debate about gun safety. That debate should be more about protecting our children, and ensuring they have the opportunity to have their needs met, and realize their potential as contributing adults, rather than about guaranteeing rights of gun ownership at all costs – especially when the cost is our children and youth. As I researched the literature and data in preparation for this letter, I determined that many had already done the research, and organized the information in effective and powerful ways. So, what follows in this letter are a few framing statistics, a fact sheet from the Children's Defense Fund, and some closing remarks from the heart.

SAVE THE DATE

Presented by:
Inland Empire Perinatal Mental Health Collaborative, The Wylie Center, and Riverside County Department of Mental Health

June 3 - Monday

8am - 5pm
Maternal Mental Health: A Medical and Legal Perspective
Speakers:
George Parnham, Esq. and Lucy Puryear, MD

6pm - 9pm
Postpartum Psychosis: Medical and Legal Consequences
Speakers:
George Parnham, Esq. and a SouthernCalifornia Reproductive Psychiatrist

WHERE:
Crestmore Manor
4600 Crestmore Drive
Riverside, CA 92509

Crestmore Manor offers a modern state-of-the-art training facility located on the remains of a farm. With its enchanting gardens and twinkling lights we hope to make you better informed on how to best serve women, either legally or medically, who may have this disorder. IEPMHC – your host of the evening, will provide everyone with practical resources for their professional use in the future when preparing for trial or to formulate medical decisions which are in the best interest of your client.

For more information or to register to attend:
email Ldryan@wyliecenter.org and request a finalized flier be forwarded to your e mail.

(We anticipate providing MCLE and CE's for MDs as well as for other healthcare providers.)

Unpleasant Truths: The Effects of Gun Violence on Children and Youth

Despite a gradual decline in gun-related deaths among teenagers over the past decade, the United States leads all high-income countries across the globe (i.e., Countries of the Organization of Economic Cooperation and Development) in the number of guns per capita, and in gun homicide rates (35.7 times higher than any other single country and higher than all other high-income countries combined).

A gun kept in the home is 43 times more likely to kill someone known to the family than an intruder or stranger threatening the family.

The financial cost to society of gun-related assaults and homicides exceeds $17 Billion per year, most of which (>$16 Billion) occurs due to lost productivity.

Firearms remain the most common mode of suicide among youth 15-19 years of age.

From the Children's Defense Fund Fact Sheet "Protect Children, Not Guns: The Truth About Guns." March 29, 2013

1. **A gun in the home increases the risk of homicide, suicide, and accidental death.** Contrary to what many people believe, having a gun in your home doesn't make you safer but instead endangers you and your loved ones. A gun in the home makes the likelihood of homicide three times higher, suicide three to five times higher, and accidental death four times higher. For every time a gun in the home injures or kills in self-defense, there are 11 completed and attempted gun suicides, seven criminal assaults and homicides with a gun, and four unintentional shooting deaths or injuries.

2. **Many children live in homes with loaded and unlocked guns.** Every parent and grandparent needs to be careful where their children play and ask if there is a gun in the home. One third of all households with children younger than eighteen have a gun and more than 40 percent of those households store their guns unlocked. Twenty-two percent of children with gun-owning parents handled guns in their homes without their parents' knowledge. More than half of youth who committed suicide with a gun obtained the gun from their home, usually a parent's gun.

3. **Guns make violence more deadly.** Contrary to what the gun industry says, guns do kill people. Guns make killing easy, efficient, and somewhat impersonal, thereby increasing the lethality of anger and violence. An estimated 41 percent of gun-related homicides and 94 percent of gun-related suicides would not occur if no guns were present. In family and intimate assaults the use of a gun increased the risk of death 12 times.

4. **Better enforcement of current gun safety laws is needed but is not enough.** There is no question that we need to improve enforcement of current gun laws so that federal agencies have the information and authority they need to deny gun purchases to criminals and those who are a danger to themselves and others, and so that these agencies can go after illegal gun trafficking. However, this isn't enough. Under current law almost anyone can buy a gun without a background

check. Federal law requires that anyone purchasing a gun from a federally licensed dealer submit to a background check. But private sales, like many sales at gun shows and increasingly on the internet, do not require a background check. A 1997 National Institute of Justice survey found that around 40 percent of all firearm sales are private sales and therefore take place without any kind of background check. This is a loophole used by many people who could not pass a background check. In 2009, undercover stings at gun shows in Nevada, Ohio, and Tennessee revealed that 63 percent of private sellers sold guns to purchasers who stated that they would be unable to pass a background check. And a 2011 study of internet gun sales found that 62 percent of sellers agreed to sell a gun to a buyer who said he probably couldn't pass a background check.

5. **The Consumer Product Safety Commission (CPSC) is forbidden from regulating the sale and manufacture of guns.**

A 1976 amendment to the Consumer Product Safety Act specifically states that the Commission "shall make no ruling or order that restricts the manufacture or sale of guns, guns ammunition, or components of guns ammunition, including black powder or gun powder for guns." As a result, the CPSC can regulate teddy bears and toy guns but not real guns, despite the fact that they are one of the most lethal consumer products.

6. **Common sense gun safety laws help reduce gun violence while protecting the legal use of guns.**

The following gun safety laws have all been found to be effective in reducing gun violence and factors associated with gun violence. None of these regulations prevent law-abiding citizens from owning guns.

- *Tighter regulation and oversight of gun sellers.* A study using crime gun trace data from 54 U.S. cities found that diversion of guns for use in crimes is much less common in states:
  - · that license retail gun sellers;
  - · that require careful record keeping that can be reviewed by law enforcement;
  - · that require potential gun buyers to apply for a license directly with a law enforcement agency; and
  - · where law enforcement agencies conduct regular compliance inspections.
- *Requiring background checks for purchases through private sellers as well as dealers.* An analysis by Mayors Against Illegal Guns found that states that

CALENDAR OF EVENTS
AAP-CA2

May 21 - Tuesday
Doctors Without Borders Recruitment Information Session
Los Angeles CA
http://msflosangelesinfosession052113.eventbrite.com/#

June 5 - Wednesday
TOWN HALL

Keynote: "New Insights Into Infant Formulas"

Discussion Topics:
· The Importance of Lutein in Human Development
· New Otitis Controversies
· Vaccine & Flu Update
· Acne Meds
· Wart Treatments
· New Food Allergy Guidelines
· ACO Update
· Insurance Coding Rules
· Medical Assistant Duties
· & more

Featured Speaker:
Kim Cooper MD, PC

6:30 - 9 PM
Maggiano's Restaurant
6100 Topanga Canyon Blvd.
Woodland Hills, CA

RSVP:
Kenneth Saul, MD
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do not require background checks for handgun sales at gun shows export crime guns 2.5 times more frequently than states that do require such background checks.

- *Firearm prohibitions for high-risk groups.* A study in California found that denial of handgun purchase to people who have committed violent misdemeanors was associated with a decrease in risk of arrest for new gun and/or violent crimes.
- *Child access prevention laws.* Studies of child access prevention laws, which require gun owners to store their guns so that children and teens cannot access them unsupervised, have found these laws reduce accidental shootings of children by as much as 23 percent and suicides of adolescents by eight percent.
- *Well-designed assault weapons ban.* An Australian law banning semi-automatic and pump-action rifles and shotguns and buying back banned weapons was associated with decreased suicide and homicide rates and with the absence of any mass shootings in the decade following the law (compared to 11 mass shootings in the prior decade).

7. **Loopholes in prior gun safety laws prevented them from being as effective as necessary.**
The 1993 Brady Law, which required federal background checks for guns purchased from licensed retailers, did not require such checks for guns bought through private sales. Today, 40 percent of guns are bought from private sellers. The 1994 assault weapons and large capacity magazine ban did not apply to weapons and magazines manufactured prior to the ban, allowed importation of rifles that could accept large capacity magazines, and allowed the manufacture and sale of "copy cat" assault weapons with only small differences from banned models.

8. **Common sense gun safety regulations protect lawful ownership and use of guns.**
The 1994 Assault Weapons Ban that expired in 2004 protected the rights of gun owners by exempting every shotgun and hunting rifle in use at the time. Senator Dianne Feinstein's proposed 2013 legislation reinstating the ban specifically exempts over 900 sporting weapons. Background checks do not prevent legal gun purchases.

9. **The majority of Americans, including gun owners and NRA members, support common sense gun safety regulation.**
Almost three-quarters of NRA members (74%) and more than four out of five gun owners (85%) believe that all potential gun buyers should be subject to a criminal background check. Nearly two thirds of Americans (65%) and half of gun owners (50%) believe that allowing people to own assault weapons makes the country a more dangerous place. Fifty-seven percent of Americans are in favor of a nationwide ban on assault weapons. A majority of Americans support banning high capacity ammunition clips (53%) and bullets designed to explode or penetrate bullet-proof vests (56%).

10. **Armed school guards and teachers will not necessarily make children safer but will jeopardize the futures of some children.**
Armed guards or officers are already in about one third of our nation's public schools. Columbine High School had an armed guard, and Virginia Tech had a full campus police force. There is no evidence that armed guards or police officers in schools make children safer. Educators are strongly opposed to arming teachers. A National Education Association poll of its membership found that only 22 percent were in favor of arming teachers, while 68 percent were opposed and 61 percent were strongly opposed. While there isn't clear evidence that armed security guards or police officers keep children in schools safer, there is very troubling evidence that their large presence on school grounds leads to the criminalization of some children, especially Black and Latino males, at increasingly younger ages and the feeding of children into the prison pipeline. Alternatives to armed guards include threat assessment teams, Positive Behavioral Interventions and Supports, and Restorative Justice Practices, which have all shown to be effective in reducing violence, improving school safety, and maintaining a positive school climate that allows teachers to teach and students to learn.

11. **Criminal background checks work; and making them universal at the federal level would make them far more effective.**
Since its implementation in 1994, the Brady Law, which instituted a federal background check requirement for sales through licensed dealers, has denied 2.1 million firearm purchase applications. However, its impact has been limited by the ability of criminals to access firearms through private sellers, who are not required to perform a background check (see Truth #4). Surveys of criminals in the 1980s, even before there was a background check requirement for sales at federally licensed dealers, found that that 80 percent of criminals obtained their weapons through private sellers. A recent study conducted by the Journal of American Medical Association found that states with background checks on private sales had 16 percent lower firearm fatality rates. This effect is likely underestimated by the ease with which guns can be trafficked from states with weak laws.

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12. **Universal background checks will not lead to a registry of gun owners.**
The Brady Law of 1994 explicitly bans the creation of a registry of gun owners. Under the law, instant criminal background checks have been made on over 100 million gun sales in the last decade, without leading to the formation of any gun registry. Claims to the contrary have paralyzed Congressional action on the issue; the vast majority of responsible gun owners support background checks because they know that the only people who will be negatively impacted are criminals and those who sell them firearms.

Advocating for an effective prevention strategy to reduce or eliminate gun-related injuries and deaths is as much a role and a medical and ethical responsibility for pediatricians as is the provision of vaccines, other preventive health measures, or any other form of anticipatory guidance. The AAP Council on Injury, Violence and Poison Prevention stated very plainly,

"The absence of guns from children's homes and communities is the most reliable and effective measure to prevent firearm related injuries in children and adolescents.",

From the AAP Policy Statement, "Firearm-Related Injuries Affecting the Pediatric Population" Pediatrics Vol. 130(5): e1416 – 1423. November, 2012.

For parents who feel they must have guns in the home, they should be informed that research argues for locking the unloaded guns and ammunition in separate locations, out of the reach of children.

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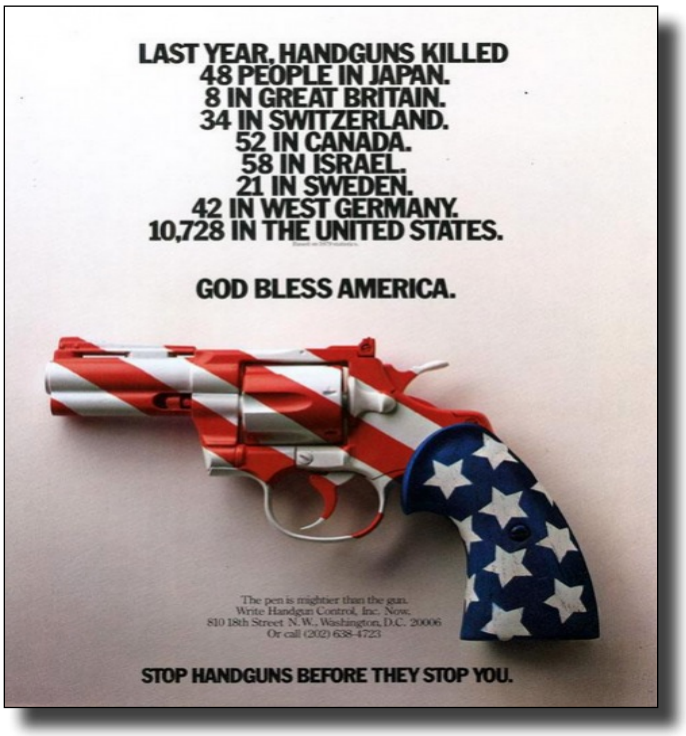

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FOR YOUR INFORMATION...

The AAP has new resources this year to add to its full range of autism-related information for pediatricians and families.

The new items include:

· **Sound Advice on Autism**
A series of audio interviews with medical experts and parents of children with autism. A new interview features James Perrin, MD, FAAP, who is a pediatric developmental expert and president-elect of the AAP. Dr. Perrin discusses the latest in autism research, diagnosis, and treatment.
http://www.healthychildren.org/English/health-issues/conditions/developmental-disabilities/Pages/Sound-Advice-on-Autism.aspx?nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token

· **Autism: Caring For Children With Autism Spectrum Disorders: A Resource Toolkit For Clinicians**
Now is available as a digital download or CD-ROM and includes tested screening tools, clinical fact sheets, and family handouts in both English and Spanish.
https://www.nfaap.org/netforum/eweb/dynamicpage.aspx?site=nf.aap.org&webcode=aapbks_productdetail&key=d830e6db-10a1-49f0-8ef1-83a84284de8f

· **Autism Spectrum Disorders: What Every Parent Needs to Know**
A new book that helps parents understand how autism is defined and diagnosed and provides information on behavioral and developmental therapies.
http://www.healthychildren.org/english/bookstore/pages/Autism-Spectrum-Disorders-What-Every-Parent-Needs-to-Know.aspx

Postpartum Depression:

What is my role as a pediatrician?

Caron Post, PhD
Executive Director, Los Angeles County Perinatal Mental Health Task Force
Elizabeth Kaplan, LCSW
Policy Coordinator, Los Angeles County Perinatal Mental Health Task Force

Perinatal depression, often referred to as postpartum depression (PPD), is the most common complication of childbirth, with an estimated prevalence of 15-20%.[1] Nationally, the AAP estimates that more than 400,000 infants are born each year to mothers who are depressed.[2] In Los Angeles County, over 22,000 women experience clinical perinatal depression each year. Left untreated, perinatal depression leads to long-term depression in the mother, a lack of emotional availability for the baby and detrimental outcomes in the development of the fetus, newborn and developing child. However, perinatal depression is highly treatable and often preventable. Pediatricians have a unique opportunity to detect perinatal depression given that they see the new mother and baby a minimum of seven times during the the first year of life. By incorporating routine screening for perinatal depression into these early well-child visits, pediatricians can help depressed women and their children by identifying and referring women for care.

Perinatal depression encompasses a range of mood disorders that can affect a woman during pregnancy and around the time of birth. Technically, it is defined as a period of at least 2 weeks during which there is depressed mood, pronounced anxiety or loss of interest or pleasure in most activities. It can occur anytime between conception and 12 months after giving birth. Often confused with the baby blues, which is distinguished by mild, transient symptoms that occur approximately 3 or 4 days after delivery and diminish by 2 weeks postpartum, signs and symptoms of perinatal depression include:

- Sadness
- Crying
- Sleep difficulty (particularly if mother is unable to sleep when baby is sleeping)
- Mood swings
- Irritability
- Feeling overwhelmed
- Excessive worry or fears
- Social isolation
- Anhedonia
- Difficulty making decisions or confusion
- Loss of appetite

Generally, symptoms emerge within the first 3 months of a child's life. There is a second cluster of women that present with perinatal depression around 6 to 9 months postpartum, up to year. The duration of postpartum depression is different for every woman. Left untreated, depression can become chronic leading to more pronounced effects on the developing child. The recurrence rate for future pregnancies is 50-75%, making planning and referral critical.

Unlike PPD, another much more severe mental disorder that can occur during the postpartum period is postpartum psychosis. This disorder affects 1 to 4 women out of 1000 live births and has a more acute onset at about 2 weeks week post delivery. Women with postpartum psychosis often have a family history of mental illness (schizophrenia, bipolar disorder, etc.). Women showing symptoms of postpartum psychosis should be hospitalized immediately as it is considered a medical emergency and has an increased risk for suicide and infanticide.

No woman is immune to the development of perinatal depression. It can affect women of all ages and socioeconomic backgrounds. However, some new mothers are at increased risk.[3] A few risk factors include: family history of mental illness, early trauma and loss, unplanned pregnancy, premature birth, history of infertility, multiple births, intimate partner violence and lack of social support. The number one risk factor for postpartum depression is symptoms of depression and anxiety during pregnancy.

The effects of untreated perinatal depression on the mother, child and family can be profound. Mothers with postpartum depression are less likely to engage in behaviors that promote early development, such as talking or singing to their baby, reading to their baby and playing with the baby. They are less likely to embrace routines, such as bedtimes and mealtimes, or to follow pediatric guidelines. Depression during the postpartum period can interfere with a mother's ability to bond with her baby and form a positive attachment. Oftentimes, depression can result in a mother who is unable to respond to her infant's cues and thus resulting in general neglect and abuse. Other effects of perinatal depression on the mother, infant and family are illustrated in the table below:

MOTHER	INFANT	FAMILY
Long term depression/ anxiety	Poor attachment	Marital friction/ Divorce
Impaired care taking of self and others	Increased risk for failure to thrive	Effects on siblings
Increased risk of substance abuse	Increased risk for abuse or neglect	Paternal Postpartum depression
Increased risk of smoking	Poor Weight gain	Stress
Sleep Disturbance	Increased dysregulation, crying or irritability	Family distress and conflict
Suicidal thoughts	Pre-term delivery	Safety concerns

ON THE WEB

Lice Lessons Campaign: http://www.nasn.org/ToolsResources/HeadLicePediculosisCapitis/LiceLessons

Since the interaction between parent and infant is central to the infant's physical, cognitive, social and emotional development, as well as to his/her ability to self regulate, it is critical to detect maternal depression in order to assist the mother and ensure a normative course of development for the baby. The pediatrician's relationship with the new mother- infant dyad is a unique opportunity to assess and help mothers suffering from postpartum depression. The American Academy of Pediatrics (AAP) has encouraged pediatric practices to create a system, such as screening, to better identify postpartum depression and ensure a healthier parent-child relationship.

The two most commonly used screening tools for perinatal depression are the Edinburgh Postpartum Depression Screen (EPDS) and the Patient Health Questionnaire (PHQ2 or PHQ9), both of which are available free-of-charge and in multiple languages. These screens should be administered at each well-child visit during the child's first year of life. Both the EPDS and the PHQ9 also address suicidal ideation and should be asked and reviewed in accordance with clinic policy. Any practice or clinic wishing to adapt screening should consult with psychotherapists and psychiatrists in their institution and/or community to develop a protocol to address the needs of the patients and physicians. Studies done to assess the feasibility of screening during well-child visits note that screens are well received, with very few mothers declining. Standardized tools can be self administered, ideally while mother is in a waiting room. Current technology trends have shown an increase in iPad or other computer devices making administration and scoring easier. Scoring can be done by a nurse or a medical assistant prior to the pediatrician entering the exam room, similar to height and weight measurements. Clinician time demands are modest, with most screenings requiring no additional discussion, 20-30% requiring brief discussions (less than 3 minutes), and only 4-5% requiring a longer discussion.[4]

If screening determines that a woman is suffering from symptoms of postpartum depression, pediatricians are encouraged to refer the mother to her primary care provider or to a mental health professional in the pediatrician's office, if one is co-located. A "warm" referral to a trusted community practitioner can also yield excellent results. A warm referral includes connecting the woman with help and following up to see if the referral was successful. Treatment options may include psychotherapy, groups and sometimes medication. The Los Angeles County Perinatal Mental Health Task Force has has partnered with 211 LA to develop a Perinatal Mental Health Resource database. For resources in Los Angeles County, please contact 2-1-1 or Postpartum Support International, 1-800-944-4PPD and www.postpartum.net.

Many physicians often worry about how to talk to a mother about her feelings. Important messages for mom include:

- You are not alone.
- This is not your fault.
- Help is available
- Treatment is effective for most patients.

In addition, the National Research Council and Institute of Medicine 2009 report[5] recommends that a focus on positive parenting and child development be paired with treatment of parental depression to prevent adverse outcomes in the child, enhance the parent's interactions with the child and help engage the parent in treatment.

In conclusion, creating a feasible intervention for perinatal depression in pediatric offices is important because the longer that treatment for PPD is delayed, the greater the duration, risks and adverse effects PPD can have on the new family.[6] The childbearing years are an opportune time for interventions because women have contact with health care professionals, have access to health insurance and are motivated toward positive behaviors to invest in their offsprings welfare.[7] New mothers are a particularly captive audience who often feel a sense of trust with their pediatrician, allowing for a long lasting relationship. Most new mothers who are suffering from perinatal depression will fail to recognize their symptoms and may not receive mental health treatment, making the pediatrician the sole medical provider with whom the mother is in contact on a regular basis.

For more information, please download Screening for Postpartum Depression at Well Child Visits (http://www.maternalmentalhealthla.org/images/providers/Screening%20at%20Well%20Child%20Visits.pdf), a policy statement written by the Los Angeles Best Babies Network and the Los Angeles County Perinatal Mental Health Task Force.

The Los Angeles County Perinatal Mental Health Task Force aims to remove barriers to the prevention, screening and treatment of prenatal and postpartum depression in Los Angeles County. It's Training & Technical Assistance program improves the ability of health care and community providers to respond to perinatal mood and anxiety disorders so that families who are suffering can receive informed help. The program provides basic and advanced trainings on perinatal mood and anxiety disorders to a variety of audiences, including pediatricians, OBGYNs, primary care providers, case managers, social workers, mental health professionals, day care providers, nurses, home visitors, hospital administrators, promotoras, military and veteran service providers and more. Trainings, which are tailored and customized to meet the needs of each audience, address the causes, signs, symptoms, risk factors, effects, screening, assessment, prevention, intervention, support and treatment of perinatal depression and related mood disorders. Agencies that demonstrate a particular interest and commitment to improving the maternal mental health of their clients are invited to move beyond an initial training and participate in the Task Force's technical assistance activities.

Together with the Task Force, these organizations devise a set of goals and activities aimed at improving screening, treatment and referral rates for their clients. The Task Force provides ongoing training, mentoring, coaching and other forms of consultation to these organizations as they work to integrate validated screening tools into their daily operations, build a database of community resources and improve the ability of their own staff to provide counseling, therapy and case management to women and families. If you are a pediatrician who would like more information about screening in your practice, please contact us at: MaternalMentalHealthLA.org.

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Management of Traumatic Dental Injuries

Mary Shannon, DDS
Board Certified Pediatric Dentist

The greatest incidence of trauma to the primary teeth occurs at 2 to 3 years of age, when motor coordination is developing. The most common injuries to permanent teeth occur secondary to falls, followed by traffic accidents, violence and sports. As pediatric dentists, we encourage the use of protective gear, including mouthguards, which help distribute forces of impact and reduce the risk of severe injury. When traumatic injuries occur to teeth, the treatment is based on several factors: whether the teeth are primary versus permanent, the extent of the trauma and prognosis of the traumatized tooth.

The following recommendations apply to the most common dental emergencies that are seen in pediatric offices or emergency rooms.

1. **Small crown fracture/ "chipped tooth":** Enamel, dentin and cementum fracture without pulp exposure
   - **Primary teeth:** If tooth is not luxated or misaligned and the trauma appears as a break on the edge or corner of the tooth, no treatment is necessary unless the broken edge of the tooth is sharp and bothering the child or if the tooth is sensitive to cold air. Advise parents that teeth may discolor due to trauma and disruption of the blood vessels in the tooth, but may return to the normal color once the tooth heals. A follow-up with a dentist is recommended, but not urgent. If the child reports sensitivity to hot or cold, a follow-up with the dentist is recommended to cover the exposed dentin with a thermal liner. A radiograph may or may not be necessary if teeth are not mobile.
   - **Permanent teeth:** Likewise, if the tooth is not misaligned and a break in the corner of the tooth is the only sequel, no treatment is necessary unless the tooth is sensitive to cold. A follow-up to the dentist is recommended, to make sure there are no root fractures.

   In both cases, advise parents to have child avoid biting with the front teeth for 1-2 weeks to allow healing.

ON THE WEB

For more information on RSV and prevention

visit http://www.cdc.gov/rsv/about/index.html

Information on flu vaccines

visit http://publichealth.lacounty.gov/ip/flu/FluLocatorMain.htm

ISMP National Vaccine Error Reporting Program

http://verp.ismp.org/

2. **Large crown fractures/ "chipped tooth with visibly exposed pulp":** Enamel, dentin and cementum fracture with pulp exposure.
   - **Primary teeth:** Refer to pediatric dentist ASAP. Tooth will require immediate dental treatment.
   - **Permanent teeth:** Refer to pediatric dentist or endodontist ASAP for immediate dental treatment.

3. **Avulsed teeth:** Complete displacement of tooth out of socket
   - **Primary teeth:** Avulsed primary teeth should not be replanted because of the potential for subsequent damage to developing permanent tooth buds. If the complete tooth was avulsed, a follow-up with a dentist is recommended, but not urgent. Inform parents that permanent teeth are unlikely to be affected, as long as the alveolar bone is not fractured.
   - **Permanent teeth:** Replant ASAP and refer to a dentist for splinting. The tooth has the best prognosis if replanted immediately. If tooth cannot be replanted within 5 minutes, it should be stored in a medium that will help maintain vitality. The best transportation media for avulsed teeth in order or preference: Viaspan, Hank's Balanced Salt Solution, cold milk, saliva, physiologic saline, or water. Water is probably the least desirable transport medium, but is better than dry storage.

4. **Lateral luxation:** Displacement of the tooth in a direction other than axially
   - **Primary teeth:** No treatment if the traumatized tooth has no occlusal interference. If the traumatized tooth is hitting another tooth, gently reposition. Refer to dentist for follow-up.
   - **Permanent teeth:** Reposition ASAP and refer to dentist for splinting. Teeth that need manual repositioning generally have an increased risk of pulp necrosis compared to teeth that are left to spontaneously reposition.

5. **Intrusion:** Apical displacement of the tooth into the alveolar bone
   - **Primary teeth:** No treatment. Allow spontaneous reeruption. Follow up with dentist ASAP for radiographs to check if tooth is displaced into the developing permanent tooth.
   - **Permanent teeth:** Refer to dentist ASAP to assess repositioning. 90% of intruded primary teeth reerupt spontaneously in 2-6 months. Immature permanent teeth that are allowed to reposition spontaneously demonstrate the lowest risk for healing complications.

5. **Subluxation:** Injury to tooth-supporting structures with abnormal loosening but without tooth displacement.
   - **Primary teeth:** No treatment necessary. Advise parents to avoid having child bite with front teeth for 2-3 weeks to allow for healing and follow-up with pediatric dentist.
   - **Permanent teeth:** Refer to dentist for splint or stabilization of mobile teeth ASAP.

General prognosis is usually favorable. The primary tooth should return to normal within 2 weeks.

Although is impossible to sterilize an oral injury site, every effort should be made to minimize bacterial contamination. A simple use of an antiseptic agent such as chlorhexidine solution is also generally recommended. There is limited clinical data to support the use of antibiotics to improve the outcome following dental injuries. Still, antibiotics are almost universally used. Similarly, the use of anti-inflammatories following traumatic injuries are commonly used to reduce periodontal ligament inflammation.

*The material presented in this article is based on recommendations from the American Academy of Pediatric Dentistry Reference Manual 2010/2011 and supporting research articles.

A list of references are available upon request.

Current Practices in Evaluation of Hypertension in Children and Adolescents

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Hypertension (HTN) is a global epidemic. One of 4 adults suffers from HTN and its consequences. HTN contributes to 49% of ischemic heart disease, 62% of strokes and has become the most common risk for death across the globe. Of even more concern, according to the Framingham report, 90% of normotensive 55 year olds will develop HTN in their lifetime.[1] The global obesity epidemic is a major contributor to this HTN epidemic. Over the past few decades, there has also been a substantial increase in the prevalence of overweight and obesity among children and adolescents. In the US, obesity (BMI ≥95th%) prevalence increased from 13.8% in 1999-2000 to 16% in 2003-2004 in females, and from 14% in 1999-2000 to 18.2% in 2003-2004 in males.[2]

Increasing childhood BMI is also associated with rise in childhood blood pressure (BP). A comparison of the third National Health and Nutrition Examination Surveys from 1988-1994 (NHANES III) and NHANES 1999-2000, showed a significant increase in systolic and diastolic BP between the 1988-1994 and 1999-2000 time periods in children 8-17 years of age, in all races, ethnicities and both genders. The increase in the prevalence of overweight in the same population over the two time periods studied was associated with the increased BP.[3]

Assessment of HTN in children

The 2004 "Fourth Report" on Childhood HTN created new BP standards based on height percentiles as well as age and gender. It provides a rationale for early identification, evaluation and treatment of children with elevated BP, and makes therapeutic recommendations, including non-pharmacologic treatments.[4]

Definitions according to the "Fourth Report" on Childhood HTN include:

- **Normal BP:** average SBP and DBP less than the 90th percentile for sex, age, and height
- **White-coat hypertension (WCH):** BP levels above the 95th percentile in a physician's office or clinic, but normal outside a clinical setting (ambulatory BP monitoring is usually required to make this diagnosis)
- **Prehypertension:** average SBP or DBP levels that are greater than or equal to the 90th percentile, but less than the 95th percentile. (Adolescents with BP levels greater than or equal to 120/80 mmHg should be considered prehypertensive)
- **Hypertension:** average SBP and/or DBP that is greater than or equal to the 95th percentile for sex, age, and height on 3 or more occasions
  - **Stage 1:** 95th%-99th%
  - **Stage 2:** ≥99th%
- **Masked HTN:** Normal BP in a physician's office or clinic, but BP levels above the 95th percentile on ambulatory BP monitoring

Ambulatory Blood Pressure Monitoring (ABPM)

Patients wear a lightweight BP monitor which measures BP at regular intervals for 24 hours. The readings are recorded by the monitor and later downloaded to the interpreter's personal computer. Equipment is available for use in children over 5 years of age, and the validity of ABPM has been confirmed in children.

Figure 1 - Ambulatory Blood Pressure

New definitions created based on ABPM:

- **BP load:** The % of valid ambulatory BP measures that are above a set value (i.e., 90th% or 95th%) for age, gender and height. A load > 25-30% is considered elevated, and a load > 50% is predictive of left ventricular hypertrophy (LVH) in children.[5]
- **Nocturnal dipping:** A physiologic decrease in SBP and DBP at night. A ≥10% decrease in mean SBP and DBP from day to night is considered a normal nocturnal dipping. A blunted nocturnal dipping is associated with chronic kidney disease and renal function deterioration.

The use of ABPM in children:

- **Masked HTN:** ABPM has found to be valuable in diagnosing masked HTN. A study of 592 children by ABPM and casual BP determined that 45 (7.6%), with a mean age 10.2 years, had masked HTN. Compared to normotensive children, those with masked HTN were more obese, had higher pulse rates, had higher left ventricular mass indexes and a greater frequency of parental HTN.[6]

The Chronic Kidney Disease in Children study (CKiD) is the largest North American multicenter study (50 centers) of children with CKD. A cohort of 586 children aged 1-16 years with estimated GFR of 30-90 ml/min/1.73m2 was enrolled into the initial phase of the study. Two of the aims of the CKiD study were to identify and quantify novel and traditional risk factors for progression of CKD, and to describe the cardiovascular disease and associated risk factors in children with different stages of CKD.[7] Of 366 of CKiD participants who underwent ABP monitoring, 38% had masked systolic or diastolic hypertension. Among children with masked hypertension, 29% were not taking antihypertensive medications, compared with only 15% of confirmed hypertensive patients who were untreated.

- **Secondary HTN:** Patients with some forms of secondary hypertension, most notably chronic kidney disease, have been shown to have different ABPM patterns than patients with primary hypertension, thus ABPM has been examined as a tool for predicting the likelihood of secondary hypertension.

In the CKiD study, 54% of 432 children had either systolic or diastolic BP ≥95th% or a history of hypertension despite current antihypertensive medication use. Thirty seven percent of patients had a measured BP ≥90th% at time of enrollment into the study, 39% of those, were not receiving antihypertensive treatment. Sixty eight percent of patients with elevated systolic BP (≥90th%) and 53% of patients with elevated diastolic BP were prescribed antihypertensive medications, however 48% of those being treated for hypertension remained uncontrolled (BP ≥ 90th%).[8]

- **Target organ damage:** Seventeen percent of all the CKiD study participants had LVH and 9% had concentric left ventricular remodeling. LVH was more frequent in children with confirmed (34%) and masked (20%) systolic or diastolic hypertension than in children with normal BP (8%). Given masked hypertension's strong association with LVH, the authors recommended early ABPM and echocardiography as part of standard care in children with CKD.[9]

Conclusions

As the prevalence of childhood obesity has increased in recent decades, so has the incidence of hypertension in children and adolescents. The 2004 "Fourth Report" on Childhood HTN created new BP standards based on height percentiles as well as age and gender, allowing a more rigorous classification of childhood BP into normal, pre-hypertension, stage I and stage II hypertension. ABPM is a powerful tool for the investigation of children and adolescents with suspected or known HTN, with the potential to streamline the evaluation of children with elevated BP. Since hypertension in the pediatric population has been shown to be associated with target organ damage, it is important to diagnose, evaluate and treat hypertension early and effectively.

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PROS:
Pediatric Research in Office Settings

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Just returned from another productive and exciting PROS meeting in snowy Chicago!
We received updates on closing studies CEASE (Clinical Effort Against Second hand Smoke) and BMI2 (Brief Motivational Interviewing to reduce childhood BMI) Both show interesting results and are awaiting final analysis. Abstracts from both studies will be presented at the Pediatric Academic Societies Meeting this May in Baltimore, with one of the CEASE abstracts being presented at the AAP Presidential Plenary.

We are almost at the close of the Teen Driving Study, an important dissemination study to help parents minimize the risks associated with teen driving, especially the first 6-12 months of driving alone. For those who have signed up for the study, we urge you to finish the very easy training and start recruitment of parents. For those who have started, please try to refer as many parents as possible to the website. Even if you are seeing the parents without the teen driver, you can recruit them into the study! The data collection on the study will end July 14th. Now that the flu season is coming to an end, please try to remember to direct the parents of children coming in for their well child and sports physicals.

PROS continues to recruit for the AHIPP study to address two risks in the adolescent population. Participants can now get MOC part IV Credit!!!! Practices that see a fair number of teens who smoke are especially encouraged to join!

ePROS, the electronic medical records subset of PROS is actively recruiting offices who use EMR. ePROS will work with your vendor and/or IT personnel to streamline the integration of your practice into the network, and address whatever concerns you might have, including confidentiality and HIPPA compliance.

Exciting studies currently and soon to be underway for ePROS include studies on AHDH decision support, psychiatric medication use in pediatrics and polypharmacy, asthma patient portal for Meaningful Use part III, and antibiotic use and parent satisfaction which could be a MOC Part IV Program. These studies will have the added benefit of easy, seamless data gathering, off site informed consent process when needed, and relatively quick access to data which can provide the added benefit of practice specific feedback.

PROS is also collaborating with CORNET, the Continuity Clinic Office based Research Network in many of the nation's pediatric residency programs as well as working with QuIIN, the AAP's Quality Improvement and Innovation Network to coordinate the implementation and dissemination of the new knowledge learned from PROS studies.

As practices evolve with changes in healthcare and as the new generation of practitioners enter pediatric practice, PROS is very interested in getting input from the younger practitioners and added a liaison from the Section on Young Physicians. We encourage ALL practitioners to join and help in the learning process to promote the health of our children and improve the practice of pediatrics.

An Update on Healthy Family Program Transitions

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Last year Governor Brown prevailed with his budget proposal to phase out California's Healthy Families Program, and shift all 870,000 children into Medi-Cal. The Children's Partnership has been monitoring the progress of these transitions and is pleased to share this update.

The transitions began in January and will proceed in four phases throughout 2013. The first phase, which involves 368,000 children is still underway and is expected to be completed in May, when 63,000 transitions in Los Angeles and Sacramento will take place. This first wave of transitions was designed for families where no change in plans or providers was anticipated, and involved families throughout the state. Phase 2 began on April 2, 2013 and will include 228,000 children who are currently enrolled in plans that are sub-contractors of a Medi-Cal plan. Phase 3, which will begin no sooner than August 1, 2013, will move 135,000 children enrolled in a Healthy Families plan that is not a Medi-Cal plan and does not sub-contract with Medi-Cal into a Medi-Cal health plan available in their county. The final phase of the transitions will begin no earlier than September 1, 2013 and is expected to transition approximately 43,000 children residing in counties that are not in Medi-Cal managed care into the Medi-Cal fee-for-service delivery system. The transitions, expected to be completed before the end of the year, were authorized by new Medi-Cal income eligibility standards that permit children in families with incomes up to 250% FPL to now be served in Medi-Cal.

Various conditions were attached to the legislature's approval of the Governor's budget proposal to eliminate the Healthy Families Program. The California Health and Human Services Agency was required to engage with stakeholders, submit a Strategic Plan and Implementation Plans, and conduct Network Adequacy Assessments. The Department of Health Care Services was required to send Notices to transitioning families well in advance of transitioning their children, and also required to submit monthly reports to the legislature on the progress of the transitions. Each Phase will require the state to produce an implementation plan, including information on health and dental plan network adequacy, continuity of care, eligibility and enrollment requirements, consumer protections, and family notifications. In addition, the Bridge to Reform Section 1115 Demonstration Waiver Amendments, Special Terms and Conditions (STC) #117 also requires the department to submit monthly reports to the Centers for Medicare and Medicaid Services (CMS) for review and approval prior to commencing subsequent transition Phases.

The Children's Partnership participated in numerous stakeholder webinars and meetings, and frequently shared recommendations regarding Notices, planning and reporting needs, and enrollment procedures. We also raised questions about how network adequacy would be determined so that families could be assured that doctors would be available to care for their children. Concerns about network adequacy were elevated because Medi-Cal providers receive a significantly lower reimbursement rate than Healthy Family providers, and it has been widely understood that many Healthy Families providers would not choose to continue to serve families when they shifted into Medi-Cal. This concern was further exacerbated by previous state-ordered reimbursement rate reductions, which are currently under review by the courts. This income uncertainty for providers has no doubt clouded provider commitments and assurances that the Medi-Cal network will be robust enough to absorb the 870,000 additional Health Families children. In fact, possible disruptions to continuity of care were revealed in the network assessment process, resulting in Phase 1 being sub-divided into four smaller transition groups, in order to give the Department more time to address provider issues. Specific concerns about Health Net plans in Kern, Los Angeles, Sacramento, San Diego, Stanislaus and Tulare counties caused those transitions to be postponed until the end of Phase 1 (May 2013).

We also often suggested that the Department needed to send information not only to families, but to community assisters and providers as well, so that they were fully informed of changes patients might encounter. Reports suggest that those community communications have not generally taken place.

While the Governor's administration maintains that the Healthy Families transition "will help streamline and simplify government health care programs for California children" (California Healthline, 12/5/12), that remains to be seen.

The Department's first two monitoring reports to the legislature (February 15 and March 15) reported few problems in the initial first phase transitions. 99.85 % of children transferred in the first phase, as expected, remained with the same health plan and provider. Nonetheless, several observers at recent legislative oversight hearings noted that the departmental reports included limited monitoring and failed to seek information directly from the Healthy Families Program – where, as it turns out, thousands of families have called with questions or concerns. According to MRMIB, which administers the Healthy Families Program, calls significantly increased after Notices of the transitions came out in November. In October MRMIB received fewer than 1,000 calls related to the transition. In November there were more than 15,000 calls, in December almost 13,000, and by mid-January there still were more than 7,000.

It was noted that Notices sent to families did not ask families to advise the Department of Health Care Services of problems, and did not even provide a phone number for such calls - rather, the Notices directed parents to contact their health plans.

At an April 4, 2013 Senate Budget Sub-Committee hearing on the Healthy Families transition, it was reported that although the Governor's administration had projected budget savings of $13.1 million in the first year of the transitions, actual savings of only $129,000 have materialized.

Another serious concern about the Healthy Family Program transition also surfaced at the Senate Budget Sub-Committee hearing regarding discontinuation of autism behavioral health care. So far, approximately 200 children have had their services discontinued. Families reported relying on Notices sent to families by the state that read "Your child will continue to have health, dental, mental health, alcohol and drug treatment, vision and other behavioral health services during this move" (November 1, 2012 Notice), and the February 1, 2013 "Frequently Asked Questions" Notice enclosure statement that reads "The Medi-Cal Program covers all of the same benefits that the Healthy Families Program now covers," and states, in response to the question "Can my child still get medical, vision, dental, mental health, alcohol and drug treatment, and other behavioral health services under Medi-Cal?" "Yes, Medi-Cal will cover diagnostic and treatment services your child needs." In spite of such Notices, numerous emotional stories were recounted by families with children receiving ABA (applied behavioral analysis) autism care that their child's care had been discontinued and that they had been referred to Regional Centers, which were not equipped to assume their child's care and behavioral health service needs. The matter – which appears to impact children in all Healthy Family plans – is under review by the Department of Health Care Services. Apparently, since July 1, health plans have been required to provide these services under state law, but ABA care is not a specific covered benefit under Medi-Cal. The Department acknowledged at the hearing that, notwithstanding their Notice to the contrary, not all behavioral health services provided for autism care would continue to be provided to families in their new Medi-Cal plans, and that arrangements would need to be made through counties and Regional Centers.

Clearly, the final two transition Phases, which will begin in August and September, could pose additional challenges as families move into new Medi-Cal plans and Fee-for-Service delivery systems.

More information is available at: www.DHCS.ca.gov or dhcshealthyfamilies@dhcs.ca.gov. Families and providers can also contact the Department of Health Care Services' Medi-Cal Managed Care Office of the Ombudsman at 1-888-452-8609