Summer 2020

The Perspective

A quarterly newsletter published by the National Med-Peds Residents’ Association in collaboration with the Med-Peds Program Directors Association & the AAP Section on Med-Peds

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Alas, another academic year is upon us! On behalf of the NMPRA Executive Board, I would like to extend a warm welcome to all our incredible interns who have started the amazing journey that is Med-Peds (MP) residency. Know that while the journey is often hard, you are now part of an amazing MP community, and we are always here to support you. Please never hesitate to reach out to any of us for anything, no matter how big or small. The camaraderie and support of the MP community is one of its strongest features, and we have all leaned on one another at times throughout our own journeys!

To all returning MP residents, fellows, and faculty, thanks for all that you do and for making this community what it is. These have been trying times as we all try to get used to our “new normal”, but I think MP as a field has done a remarkable job navigating this new environment. A big shoutout to Dr. Ashley Jenkins and Dr. Leah Ratner who cofounded a national collaborative, the POPCoRN network, to help enhance adult care in pediatric facilities. Many MP faculty at institutions across the country have been asked to help potentially collaborate care across the adult and peds populations during this pandemic, and I think we have truly shown the value our training and breadth of expertise brings to the table.

I also want to highlight the remarkable response by MP leadership to help optimize the drastically changed interview season for MS4s. Dr. Ron Magliola put in a tremendous amount of time and effort in leading a webinar series cosponsored by MPPDA, AAP-SOMP, and NMPRA. The series has been wildly successful, consistently hosting over 100 participants per session, and at times have had over 250 participants in a session! Session topics have ranged from a basic overview of MP, to “speed dating” info sessions on residency programs. We are looking to make the series an annual feature, to ensure students always have access to updated information on all things MP! If you haven’t been able to attend the webinars and want to check them out, head over to our website www.medpeds.org, where we are uploading all of the session recordings!

To our residents and faculty, as we continue to move forward towards interview season I challenge you to put in extra time seeking out med students that you know are interested in and/or applying MP, and making sure they have the mentorship and assistance they need. If
you don’t feel comfortable providing the mentorship yourself, or they have questions you can’t answer, you can always put them in touch with our med student guru Dr. Sasha Kapil (info@medpeds.org) who can help them out! If you’re interested in setting up a mentorship program at your institution, feel free to reach out to us as well, we would be happy to share ideas!

Another big change this year will be our switch to a virtual national conference. We will provide more details on the logistics and dates of this elsewhere, but I do want to share that the focus this year will be on improving our ability to understand and improve diversity, advocacy, health equity, and anti-racism in our MP community. We are working on collaborations to potentially host a year-round series as well, as we understand that to enact change we need to commit to a continued effort to learn more about our own biases, and how we can overcome them to provide equitable care, and create equitable systems, for all patients and colleagues.

I am also thrilled at the creation of our Med-Peds Academic Channel (MPAC), the result of an amazing amount of time and effort by so many individuals, which will serve as a platform to publish more MP relevant material, and will be PubMed indexed. Also huge thanks to our amazing past-president Dr. Colby Deny, who has led the charge on an entirely new, built from the ground up, NMPRA website that will be unveiling this Fall! The site will be much easier to navigate, and will serve as an amazing platform for hosting resources and information for all things MP.

Thank you again to each and every one of you who make up the fabric of this MP community. You are the reason I chose to go into MP, and the reason med students continue to be inspired to take on the challenge of two residencies wrapped into one. Continue to lead by example, be kind to one another, and find joy in the amazing work we are privileged enough to get to do! As always, please reach out to me with any questions, concerns, or ideas at president@medpeds.org.

Med Peds for Life #MP4L

Maximillian Cruz, MD
President, NMPRA
Internal Medicine-Pediatrics PGY-4
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A collective hello and happy summer from your program directors!

The Med/Peds Program Directors Association had our national meeting this past April (virtually instead of in sunny Tampa) in conjunction with the Association of Program Directors of Internal Medicine. The themes of the MPPDA meeting were Resident Wellness During a Pandemic, and Diversity and URM in the Med/Peds world. Since then, we and most of the country have added Anti-Racism to our national agenda, and along with our peer organizations have been working hard on establishing initiatives and policies to educate ourselves and each other, and further social justice causes. Additionally, the MPPDA has been working with the SNMA (Student National Medical Association) and LMSA (Latino Medical Student Association) to improve student advising, advocacy, and mentorship on local, regional, and national fronts. We have all become much more experienced with Zoom and WebEx and hopefully many of you have already experienced some of this virtual outreach as part of our ongoing recruitment series.

Beyond that, we continue to support Med/Peds residency programs and residents through regional meetings, regulatory advocacy, and connecting and collaborating with internal medicine and pediatric organizations. Med/Peds has a valuable and unique perspective and identity, and it is critically important that we make our voices and opinions heard as change is discussed.

We look forward to continuing our strong partnership with NMPRA.

Here’s to a great year!

John Solomonides, MD
President, MPPDA
Professor of Internal Medicine and Pediatrics
University of Massachusetts
My note in the Spring Perspectives began by stating that we were in unprecedented times due to the pandemic afflicting our nation, and thanking all of the members of our Med-Peds community— the students, residents, fellows, and practitioners, who were and are serving with such stalwart dedication throughout all of this. We continue to see the effects of this, now in different regions of our country, and I thank all of you for what you are doing.

In the midst of this, our country has come face to face yet again with the injustice that has existed since our founding. The deaths of George Floyd, Breonna Taylor, and Ahmaud Arbery are all tragic reminders of the injustices that pervade our society, including our health care system. All of the Med-Peds organizations are currently looking at what we can do as a community.

As we live in a time where everything that makes the news is immediately politicized, it is important for all of us as a community to pull together with the knowledge that we are a part of something larger than ourselves, to support anti-racism and peaceful social change, to remind everyone that social distancing, masks, and other protections are important for all of us.

And please remember that despite our crushing workload, and all else going on in the world right now, you need to take care of yourself! Please make sure you are checking in on how you are doing as well.

Thank you, and be safe.

Mike Donnelly, MD, FAAP, FACP
Chair, Section on Med-Peds (SOMP), AAP
Chair in Pediatrics, Professor of Medicine and Pediatrics
Georgetown University
National Conference 2020

PRESENTS

VIRTUAL NATIONAL CONFERENCE 2020

ON

ADVOCACY, EQUITY, AND ANTI-RACISM

We will also have additional sessions on podcasting, publishing, and more!

THURSDAY 10/8 7-9 PM EST
FRIDAY 10/9 7-9 PM EST
SATURDAY 10/10 12-3 PM EST

Stay tuned for more details on speakers and registration in a separate email!
Welcome to Recruitment Season 2020-2021!

The COVID-19 pandemic has resulted in the need to restructure the interview format in order to keep our applicants and programs as safe as possible. Our programs and leaders have worked endlessly to ensure the best interview season during this uncertain time. There have and continue to be some challenges along the way, but this process has also demonstrated the unity and strength in our tight-knit med-peds community. This is yet another reminder of why we are proud to be med-peds!

NMPRA, MPPDA, and AAP SOMP have worked to provide some resources for applicants this year. These can all be found on our website.

Med-Peds Informational Webinars
- Nine sessions that were hosted via Zoom
- Recordings of these webinars can be found at: https://medpeds.org/what-is-med-peds/med-peds-informational-webinar-series/

Residency Application Guide
- Program-specific expectations for the 2020-2021 application cycle
- Compiled by the MPPDA
- Programs continuing to be added
- Found at: https://medpeds.org/medical-students/2020-2021-residency-application-guide/
What to know about Med-Peds and Pediatric Hospital Medicine: Advice from Med-Peds Fellowship Graduates!

Pediatric hospital medicine (PHM) was approved as a subspecialty by the American Board of Medical Specialties (ABMS) in October 2016, with the first administration of the Pediatric Hospital Medicine exam offered November 2019 through the American Board of Pediatrics (ABP). For med-peds and pediatric residents graduating after June 2019, pediatric hospital medicine fellowship will be required to be PHM board-eligible.

Med-peds physicians interested in pursuing a PHM fellowship should know they can practice both pediatric and adult hospital medicine in their training and can tailor their PHM experience to reflect their career goals. All PHM fellows have the opportunity for 32 weeks of individualized curriculum. This section of the fellowship requirements was intended to be flexible to focus on the career paths of the fellows, including allowing for some adult rotations for those that will benefit from it. For med-peds candidates, these aspects of individualized curriculum can include time in internal medicine.

Our objective is to use our experiences as two med-peds graduates of pediatric hospital medicine fellowships to highlight that PHM fellowship is customizable to meet the clinical and scholarly needs of med-peds PHM fellows.

**Example 1: 2-year PHM fellowship**

I joined a new institution to complete a two-year PHM fellowship with the aim of ultimately practicing as a Med-peds hospitalist. My goals in pursuing fellowship were to develop my non-clinical career interests, including research and quality improvement, while continuing to build on my clinical knowledge base of both pediatric and adult hospital medicine. Before submitting applications, I reached out to fellowship program directors about options for incorporating internal medicine time. After Match Day, I worked with my PHM fellowship program directors and adult hospital medicine leadership to further define the fellowship “Med-peds track.” I served as a non-ACGME fellow on the pediatric side and an attending on the adult side. Internal medicine service time fulfilled my PHM elective requirement. I completed 7 weeks of internal medicine direct care service per year. I benefited from structured mentorship through the fellowship on the pediatric side. On the internal medicine side, I proactively developed a mentorship team and participated in career development opportunities available to junior hospitalists.

Lessons Learned:

Using elective time to practice adult hospital medicine allowed me to maintain my adult medicine knowledge base. It also enabled me to develop a personal practice style as a new attending while maintaining my eligibility to sit for the PHM boards. While I technically completed a pediatric fellowship, the skills I gained in my scholarly work translated well to internal medicine and made me a competitive candidate for both adult and pediatric hospitalist positions.
One notable tradeoff of using fellowship elective time for adult hospital medicine was that I did not have time remaining to pursue electives on the pediatric side. However, my schedule structure reflected my primary career goals.

**Example 2: 3-year PMH fellowship**
I stayed at the institution where I completed residency and a chief year for PHM fellowship. I had the opportunity to discuss, even before applying, the fellowship design to meet my goals as a med-peds candidate. Having institutional knowledge and relationships did help this process. I ultimately had the support of our PHM fellowship director and division to have significant flexibility in what my clinical schedule and scholarship looked like.

My overall goals in completing fellowship were to develop skills in clinical research and quality improvement scholarship. I specifically chose a 3-year fellowship given my desire to have the necessary time to develop skills in research while also having pediatric and adult medicine clinical work and scholarship. I chose to stay at my ‘home’ institution given I already knew the system clinically and could focus on new scholarly skill development.

Lessons learned:
Similarly to example 1, I could not have imagined doing three years of fellowship without having adult hospital medicine time. Ultimately, it was a nice balance between having coaching and additional support in supervised practice on the PHM side while having independent practice on the adult hospital medicine side. I was able to design electives even on the adult side such as an ‘advanced neuropsychiatry elective’ where my learning objectives focused on assessing patient capacity and competency, variation in criteria for medical and financial guardianship, etc.

**Special Considerations**

*Location of adult medicine time*
Both of us completed PHM fellowships at free-standing independent children’s hospitals. Our adult medicine time was done at separate but affiliated institutions. This meant that our designation as a clinical fellow was at the children’s hospital only. We could ultimately attend and bill when on the adult medicine services.

Full disclosure, this is a bit ‘in the weeds’ with ACGME details but important for med-peds residents considering fellowship to understand. For clinical fellows in ACGME accredited PHM fellowships (which will now be the norm), supervision (and inability to bill) is required for the first two years. If the same ACGME-accrediting body oversees clinical care in both the pediatric and adult settings, med-peds PHM fellows who wish to have adult medicine clinical time will have to navigate one of two options:

1) arranging supervision on the adult medicine side
2) moonlighting at another site where they can practice independently.

The challenges with option 2 will be navigating another health system, as well as additional clinical time that may not count towards fellowship requirements. This path also may detract
from time for scholarship. A potential benefit of option 2 is the financial incentives associated with moonlighting.

**Pursuit of an advanced degree**
Both of us pursued advanced degrees during fellowship. We want to be open in stating that including additional clinical and research goals in adult medicine makes it more challenging to do additional coursework and/or an advanced degree. Simply put, you are cramming more into the same amount of time.

There are many ways to consider additional training and education during fellowship from attending workshops, taking specific coursework, completing a certificate program, or pursuing an additional degree. It should first and foremost depend on the career objectives of the fellow. Not everyone **needs** to pursue another degree to meet their goals. Secondary considerations may include the following:

- **Accessibility of coursework**
  - Does the fellowship cover cost?
  - Is it available on-site (local institution) or virtual learning platform?
  - Do you have access to the kind of training you need (e.g. are you interested in medical education but there is only the option for an MPH?)

- **Availability of coursework**
  - Is it in-person or online?
  - Does the available coursework meet your educational needs?

- **Timing of coursework availability**
  - Is there flexibility in when classes are offered (e.g. spring vs fall)? If not, is there flexibility in scheduling clinical time?
  - Does it look like coursework can align with planned scholarship?

Overall, med-peds hospital medicine is a worthy and attainable career choice. Med-peds graduates interested in qualifying for PHM boards via the fellowship pathway have a variety of options to incorporate internal medicine clinical practice and scholarship. Early and open communication and collaboration with program and hospital leadership allows for individualized curriculum to meet the needs of the med-peds PHM fellow.

**Ashley Jenkins**  
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Graduate of UCincinnati PHM Fellowship

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Graduate of NorthwesternU PHM Fellowship
AAP Virtual Conference October 2-5, 2020

Section on Med-Peds Sunday, October 4, 2020 3-5:30pm

***Register at https://aapexperience.org/ today!***

Join the AAP Med-Peds Section!

If you belong to the AAP, membership in the Section on Med-Peds is FREE!

Join today at: http://membership.aap.org/Application/AddSectionChapterCouncil
PoPCorn Network is a collaborative group across multiple institutions looking to provide support in caring for adult patients within pediatric settings. This initiative was developed as a result of the COVID-19 pandemic by Dr. Leah Ratner and Dr. Ashley Jenkins, both incredible internal medicine-pediatrics physicians.

They are looking to develop a PoPCorn Chief Chat – a Chief Resident workgroup in an effort to help current Chiefs navigate their new roles and responsibilities in the time of a pandemic.

The goals of the group would include, but are not limited to:

- Chief Division of Labor
- Scheduling
- Education
- Resident Wellness

If you are interested in joining or have any questions, please email contact.popcornetwork@gmail.com for more information. Please feel free to invite other Chief Residents from your institution (not just med-peds!) if you feel this may be beneficial!
Interested in a new podcast?? Look no further! The Cribsiders is THE new pediatric podcast (sibling to The Curbsiders internal medicine podcast) in which experts are invited to discuss various topics which affect our younger patients. This podcast was founded by Dr. Justin Berk (med-peds), Dr. Chris Chiu (med-peds), and Dr. Matthew Watto (internal medicine). Each episode is a fun and captivating conversation, making it easy to learn! Not to mention...lots of topics unique to med-peds!

Current Episodes:

1. Cystic Fibrosis Licked-ty Split with Dr. Whittney Warren
2. Go with the High Flow: Bronchiolitis with Dr. Brian Alverson
4. Things We Do For No Reason in Pediatrics
5. MIS-C: When COVID Affects Kids

And many more to come!!

Don’t forget to follow them on social media!

Twitter: @TheCribsiders
Instagram: thecribsiders
Facebook: The Cribsiders -Pediatric Podcast

Here, you can find beautiful depictions of clinical pearls from each episode!!
That morning it seemed I had brushed my teeth in vain
From the looks on their faces, I knew nothing would be the same
Mom and Dad sat me down and told me the news
There would be no school for a while, no need for my shoes
“But, why?” I uttered with all the wonder I could muster
“There’s a bug going around.” Mom declared with a shudder
“And when can I go back? I have to see my friends.”
After a moment of silence, Dad replied “We don’t know yet.”
They turned on the news and set my assignments before me
Seemingly surrendering to this horrid reality
I was still trying to process what their words really meant
Was this how the coming days were going to be spent?
Locked away within the confines of the living room walls,
Completing work from my teacher, no recess or roll call?
No Spring Choral Show or bake sale with the band?
No horsing around in class or hall pass in my hand?
One look at the television and to my amazement I observed
All the news anchors clad in masks doing interviews on the curb
“The cases are increasing, there is no cure in sight.”
“All the stores will be closed until we get this thing right.
“If you are listening, God, I have just one request.
Can you please help us all get out of this mess?
I want everything back the way that it was
I am tired of being home doing class in pajamas
This is taking much longer than we all thought that it would
If you can stop the bug I promise to be good
That night as I laid down to retire for bed
Thoughts of the phrase “new norm” swirled about in my head
The prayer of a child seeking exile from the glum
I closed my eyes and imagined better days to come
Despite all the fear, uncertainty and doubt
I truly believe that love is the way out
We might not know when, but I know this much is true
There is still good in the world, and love is all we can do.
6.19.20

A wave of people flows west into downtown Los Angeles. Their momentum pulls you like gravity, but Old County, ahead, draws you forward.

The afternoon hospital is quiet. Pass no one on your way in. Some hours later, the sun sets outside your notice. Your eyes are filled with numbers limned in blue light. Your fingers tap, tap.

Somewhere outside the hospital, people are screaming to be seen and heard, but you hear only the clipped voices of television anchors focusing on damaged property. A reporter compares human beings to cockroaches. Turn off the stream.

Walk past the rooms of patients unable to breathe on their own - these human beings known to you only by their ventilator settings, the drips flowing into their arms, necks, groins, the milliliters of fluid positive or negative over the past twenty-four hours. Peer into negative pressure rooms to collect and copy the readings on their monitors. Glance at their ruined bodies. The roar of air filtration systems fills your ears.

This is the quietest it has been all week, but there is no tranquility tonight. A ringtone summons you upstairs to where your list has overflowed. Your patient is DNR/DNI. Relief, when you do not have to do violence tonight. You are handed death papers for the first time.

In the morning, drive past your apartment through the streets downtown in this city to witness. Shivers, because every other vehicle is painted black and white. This is not safety. Turn a corner. Anger, at the presence of camouflage and rifles defacing these streets of Los Angeles, your home for the past twelve months and the next three years.

Next week. Finally have time to medically understand your patients. Guilt, at being inside when so many are outside. Find small solace in speaking with the family members of those who cannot speak for themselves.

Leave the hospital. Eat. Sleep. Wake. To the hospital and back. Once per day between the hours of eight and eleven PM, use your voice to support people dying to be seen and heard. Life goes on as usual.

Jonas Kwok, MD
Internal Medicine-Pediatrics, PGY-2
LAC+USC Medical Center
"Aweh, doctor," a familiar phrase would often echo through the South African hospital where I was volunteering during a third-year elective. It was not uncommon to walk the wards and hear a variety of languages spoken (from Afrikaans to English to Zulu). A variety of cultures shared. A variety of medical conditions seen. As reflect back on my time in Victoria Hospital, I can think of one patient interaction that perfectly captures the healthcare challenges of South Africa and may teach US medical students a few lasting lessons, much like it taught me.

Enter Mrs. Jones, a 60-year-old female, originally from Zimbabwe. She presented to the emergency room with a two-day history of night sweats, hemoptysis, fevers, and pain upon inhalation. A CXR was performed and showed a left lung pleural reaction/effusion, a working diagnosis of tuberculosis was made. She shared her story coming from Zim where senior governmental/public doctors have been striking for the past 6 months due to unlivable wages and poor hospital conditions. For those who could not afford private insurance, you were left with two options: (1) Live with your ailments or (2) travel for care. The biggest challenge in South Africa arguably embodies the greatest healthcare challenge in global health: inequity in accessing care. Due to an overburdened system that is scarce of many resources - from imaging modalities to providers- you are left to rely on the history and physical. As medical students, we can often get caught up on the systematic approach to H&Ps (talking to you “OLDCARTS”) and relying on imaging and labs to reach a diagnosis, that we often lose sight of the fact that many times the patient is telling us exactly the diagnosis with their answers and exam. As we collectively venture into this world of medicine, we must not be scared to return to the core foundations of clinical knowledge from which we are taught.

One of the biggest draws for medical students wanting to pursue global health electives, is the idea of exploring diseases in which we are not exposed here in the United States. For many students, global health is synonymous with infectious and tropical disease. However, for every infectious disease encountered, I would encounter triple the amount of chronic diseases (HTN, Acute Coronary Syndromes, etc.). We as medical students (and as future providers) must be weary of the idea that developing countries sole health concerns are related to communicable infectious disease. As our world continues to become more interconnected, we must remember that medical ailments are not restricted by national borders or socioeconomic classes; but, the care often is confined. We must be scared of the idea of half-learning something because we would not classically see it in the US. As these past few months have shown us, continuing to learn of disease we as providers know little about is not only our duty as providers it is our duty as life-long learners.

The lessons I learned from my time in South Africa with Mrs. Jones I think can be shared amongst all students, regardless of where you’re practicing. Global health has a way of encouraging adaptability, reshaping perspectives, and forcing you to return to your core clinical knowledge. In the words of Billy Paul in the 1972 song, “Me and Mrs. Jones”, “now she’ll go her way and I’ll go mine,” but the lasting impact of her teachings will remain much longer.

Charles Shofner
University of Louisville School of Medicine, Class of 2021
My life would never be the same. I was three months into my intern year when hurricane Maria destroyed a great deal of our infrastructure and left us without power for months. I remember intubating patients while someone shined a dim cell phone light and then running towards a source of power before the battery from their respirators ran out. I remember the smell of hundreds of dead patients piling up in a small basement. Amid this national crisis, I met Angel, a young patient with HIV who was lost to follow up after becoming a legal adult. He arrived at our hospital with AIDS and a large pelvic mass that was obstructing his urinary tract. His standard genetic blueprint that harmoniously allows cellular growth had been altered, making his mutated cells grow uncontrollably, and causing vital organs to shut down one by one. Parallel to the circumstances at the time, his cancer reflected how entire systems collapse when unforeseen events threaten normalcy. His case strengthened my passion for patients with cancer and hematologic conditions, whose diseases do not wait for environmental crises to be over.

I decided I wanted to become a hematologist-oncologist early on when my grandfather was diagnosed with colorectal cancer. My father, his son-in-law, served as his Oncologist during the next five years of his life. Through their relationship, I learned to appreciate the special bond that a cancer specialist develops with his cancer patient, one that lives on in the memory of those he leaves behind. When the time came to choose my residency, I was torn between Internal Medicine and Pediatrics. I thought of all those patients I met during my clerkships as a medical student, who, like Angel, are diagnosed with chronic conditions during childhood and lose follow up once they reach adulthood. Mortality among patients with cancer and blood disorders increases significantly due to factors that are preventable with established continuity of care. Plus, I loved working with children as much as I loved working with adults and the elderly. It is because of all these reasons that I chose the Internal Medicine and Pediatrics combined residency program. It would allow me to engage with patients of all ages and life stages while learning from an endless range of pathologies. I would be able to follow survivors of childhood cancers and provide surveillance for their treatments’ toxicities. At the time, there was a new program in Puerto Rico that had yet to graduate its first class. No one knew what Med-Peds was, and many advised me against it. So, in Summer 2016, I applied to the Med-Peds residency despite doubts and plenty of criticism from family and friends but with the confidence of knowing that it just made sense for the plan I had in mind.

I am proud to be a member and Chief Resident of the first Combined Internal Medicine and Pediatrics Residency in Puerto Rico. Located in Puerto Rico’s largest public pediatric and adult hospitals, we provide medical care to a large population of underprivileged patients with complex medical and social issues. I train in an understaffed, oversaturated clinical setting in which it is up to us as residents to advocate and care for our patients despite multiple setbacks. Living on an island going through bankruptcy, which is still rebuilding after hurricanes Irma and Maria, that has suffered devastating earthquakes, and that is currently facing the greatest pandemic of our time, only added to my training’s uniqueness. Being a med-peds has shown me to be resourceful despite my circumstances. As I look back while writing my fellowship personal statement, I think of how lucky I am to be a part of this. My name is Beatriz Caceres, I am a fourth-year med-peds resident, and I plan to become the first Puerto Rican Pediatric and Adult Hematologist-Oncologist.
Communication is essential to practicing medicine. It allows us to coordinate care with other members of the healthcare team, to ensure safe handovers, and to cultivate trusting relationships with our patients.

I see at least two perspectives.

Healthcare workers attend to large volumes of patients, making it challenging to be both efficient and thorough. Some days are just busy: 25 patients on your service need to be seen during morning rounds, and you have a full day of clinic in the afternoon. Balancing efficiency and thoroughness seems impossible, and, at that point, efficiency often becomes the priority while thoroughness takes the backseat.

Patients, on the other hand, are coming to you as individuals. They entrust you with their lives and reveal their most sensitive vulnerabilities. Add in barriers of unfamiliar customs, a foreign language, and an unstable financial source to an already sensitive situation – coming to the doctor is a scary experience.

I do not think either side is to blame. The healthcare staff does their best to balance the high volume of patients and their own continuing education; patients naturally feel more at home around caregivers who speak their language and have a similar cultural background.

So how can we as healthcare workers improve this seemingly stagnant situation?

Improving larger forces at play (i.e. hospital systems, access to interpreters, reimbursement, administrative costs), optimizing our verbal communication skills, and educating ourselves about different cultures and ways of life are important and necessary steps.

But there are also the subtleties.

Given the diverse populations we as physicians serve, learning how to create a
comfortable space conducive to open communication for all in spite of language and cultural barriers is extremely relevant. The Mehrabian communication model illustrates that there are three aspects to communication: verbal, non-verbal (i.e. tone, intonation, volume), and visual (i.e. body language). Only 7% of what we communicate is conveyed by our literal words, whereas 38% is conveyed by non-verbal communication, and 55% by visual communication [1]. Therefore, the manner with which we speak and the way we carry ourselves hold far more weight than the words themselves.

Maybe we don’t have time to extensively educate patients during that hectic morning before rounds, but we can pause for two seconds to look them in the eye and smile, or put a hand on their shoulder when asking how they did overnight. These small acts can garner trust so that, perhaps, when you or another physician down the road do have time to teach, they will be in a less anxious headspace to process that information and understand. Patient education is important; I would argue creating a safe space in which patients feel empowered to change is equally important. Great potential to improve relationships lies in the subtleties: being mindful of our body language, purposeful with our gestures. Unless we are vigilant, these seemingly insignificant actions and reactions contribute to a strained physician-patient relationship.

Circumstances may prevent us from delivering optimal care despite our deep desire to do so, which can be the most frustrating. It is important to not let our frustration of the system affect the quality of care we give to our patients in that moment.

We may not always speak the same language and understand their struggles, but all humans know love, no matter the culture, no matter the language. It’s hard to determine what exactly prompted Mrs. X to open up, but I can’t help but believe that it was due in part to the environment that her previous caregivers and we created. If we make a conscious effort to express this compassion and love each day, it will be a step forward in addressing barriers to care, giving patients a voice, and making them feel at home.

Meera Iyengar
Internal Medicine-Pediatrics, PGY1
Indiana University
Lessons we learned from our patient – reflection of a third year medical student

Inspiration: Our loves for our puppies and our appreciation for the opportunity to learn and growth from taking care of our patients as third year medical students at UMMC

Before meeting my very first patient as a third-year medical student, I was excited and nervous. I had reviewed my patient’s medical chart thoroughly the night before and reviewed it again several times the next morning. I memorized her long list of medical diagnoses, medications and lab values. I anxiously knocked on the door to meet her for the first time before her big surgery that day. I had felt that I know everything about her, Ms. G, a 65-year-old woman with late stage cancer. However, as soon as I entered the room, I quickly realized that there is so much more to learn about my patient, beyond the medical record and test results. I was greeted warmly by Ms. G with her kind smile, and instantly, we had a laughful conversation about life, home, and puppies.

Ms. G shared with me about her husband, who is waiting for her in the visitor area, and that they have been married for over 30 years. She then told me about her 3 puppies, who are waiting for her at home. She joyfully told me about each of her puppies’ names and their adorable personalities. As she shared these stories with me, I saw a glimpse of gentleness in her eyes. Ms. G had been fighting cancer for over two years; but her ailment did not change who she is, a compassionate and loving person. Ms. G told me about her work as a life-long animal rights advocate. She shared stories about adopting puppies that were traumatized by their previous owners. Moved by her dedication, I shared with her about the puppy I recently adopted, Oreo, and how I am struggling to train him due to my rotation schedule. As soon as Ms. G heard my story, she told me: “Let me read you a poem I found not too long ago, which is written from a pet’s voice. It went like this:

‘What did I do?
Was it when I peed on the floor?
I’m sorry I just didn’t know yet…
Or when I chewed your favorite shoes?’”

As if Ms. G had read my thoughts and worries, she encouraged me to continue loving Oreo and communicate with him. She explained to me that the language of love is universal and reassured me to remain patient in training Oreo. As I listen to her, my worries became air, and I felt embraced by her caring wisdom. I am so grateful for the opportunity to meet Ms. G and the privilege to take care of her while she was in the hospital. From Ms. G, I learned not only about her medical conditions, but also wonderful life lessons, which I will take with me as I continue my journey in medicine.

As a medical student, I have the unique opportunity to learn about each of my patients as a person and develop a close relationship with them - an invaluable experience in my personal development and my medical endeavor.

Story by Phuong Le and Illustration by Sallie Lin
University of Mississippi Medical Center, Class of 2021
Rethinking Recruitment in a Pandemic: Increasing Our Social Media Presence

As the COVID-19 pandemic stretched into the late spring months, ACGME made the recommendation for holding all residency and fellowship recruitment for the 2021 Match cycle in a virtual manner. At University of Tennessee Health Sciences Center, preparations began to hold all interviews virtually. For the Internal Medicine-Pediatrics program, our leadership realized quickly that our online presence would need a drastic makeover. For applicants from outside of Memphis, it is often meeting our residents and seeing the city in person that would sell the program and we want to continue to attract diverse, highly qualified residents.

Our program director put out a call for a Social Media Committee, which would eventually be composed of three rising PGY2s, three rising PGY3s, and our three chiefs for the upcoming year, all rising PGY4s. Being part fulfills our requirement for serving on a committee during residency and can go on our CVs.

At our first committee meeting, we discussed our vision for how we could increase our social media presence to show Memphis, UTHSC and our residents to applicants who would not be able to experience all of it in person. We ultimately decided that Instagram and Twitter would be the main points of focus, with a minimal presence on Facebook and TikTok.

Instagram will be for highlighting residents, alumni/faculty, Memphis and wellness activities on weekdays, leaving weekends for a break or posts that do not fit well elsewhere. We will use the “takeover” model of having residents take turns showing their day on Instagram Stories, then saving those to the Highlights section. The account will be used to share posts from the categorical programs and the UTHSC main page, as well as local Memphis accounts like @choose901, @ilovememphisblog, @ediblememphis and others.

Twitter will be used to demonstrate the academic side of our program. The platform has become a bustling #MedEd conversation, full of excellent educational resources. Many of our program faculty and residents are active on the platform, sharing teaching pearls and live-tweeting conference presentations. Twitter makes it easy to share these posts to our main feed and thus to any applicants. Going forwards, we plan to share any presentations made by residents or faculty, convert our morning reports into a “Tweetorial,” and take part in discussions and webinars. Instagram posts were shared to Twitter and all of the accounts are clearly linked to the program’s profiles on other platforms.

In order to maintain consistency across the platforms, the overall team was divided into two groups, with one each to cover Twitter and Instagram. Residents will take turns covering a week of features, with a central online document to ensure a steady stream of ideas and that all residents and faculty are eventually featured.

Our plan to kick off our major social media push started June 1, which coincided with the national protests and conversation around the murder of George Floyd and #BlackLivesMatter. Knowing that this was a cultural and societal moment that we could not stand idly during, our initial content was put on hold. Memphis is a city steeped in civil rights and social justice history, and we felt that this was important to show on our platforms.
In the first month of our actively increased presence on social media, we gained 91 followers on Instagram and 106 on Twitter, with the most popular posts being those about current and recent residents. We have not made as much of an impact on TikTok but have made a few videos and are having fun brainstorming how to use the platform to create fun breaks for residents.

We knew going in that fluidity would be key and have already made some changes. The first was to transform the Instagram page to a business page, which allows us more insight into the interactions our posts get. The second was the addition of a resident pet feature on our Instagram! We hope to engage on both Twitter and Instagram with applicants and collect data both as we go and after Match with the help of those who interviewed with our program.

This recruitments season will look different than any we’ve known before. We are all huge fans of Memphis, UTHSC and our residents and colleagues. Getting to show all this to applicants who would not otherwise get to see it is the main goal of this, but we are also having a lot of fun putting all the posts together! I hope getting a close-up view regarding our program’s approach will help other programs do the same. We love to answer questions and can be reached @UTHSCMedPeds on Twitter, Instagram and TikTok!

Melanie Watt
Internal Medicine-Pediatrics, PGY3
University of Tennessee Health Science Center

@uthscmedpeds

Be sure to look for the various med-peds programs on Instagram and Twitter!
When I think about Sara, I think about her past. I met her on a Thursday night in the emergency room, where she had presented for the fifth time this year. She was fifty-seven and had already collected several diagnoses that populated her problem list: obesity, type 2 diabetes, hypertension, and asthma. Her blood pressures stubbornly resisted the effects of every medication she tried, and her creatinine was creeping up with each repeat BMP. She had been warned that she may need dialysis soon. She told me that she often felt anxious, and that the occasional cigarette was the only respite she’d found from her racing thoughts. When the pandemic began touching the homes of her neighbors and friends, she became even more worried. She was aware that she would be at high risk of complications if she were to contract the virus, and yet she felt she had no way to control her trajectory, and no power to reverse the conditions she already lived with. “I guess some ships have sailed,” she lamented, as if the stretcher she lay on were a lifeboat with a slow and steady leak.

When I think about the future, I think about Rosie. I met her on a Tuesday morning in pediatrics clinic. She was a sweet girl with a glowing smile who had come in for her 8-year old well-child check. She was only in second grade, but her body seemed much older. Her rounded belly was pressed out under her pink cotton shirt, and the folds of her skin spoke the velvety whisper of elevated blood glucose. Her mother told me that she was so anxious about coronavirus that she was having difficulty sleeping and paying attention in school, and a recent asthma flare had made her reluctant to play outside. When it was time for her exam, she struggled to climb up on the exam table, her growing bones already tired of carrying extra weight.

When we think about the future, it may seem that uncertainty is the only guarantee. Though the scientific community warned of a potential pandemic for decades, most of us did not anticipate living life as we are today. Indeed, there is so much we did not anticipate, so much we cannot know. The world will heal in unpredictable ways. Communities will undoubtedly end up with ugly scars, while certain painful societal wounds will fade with grace and time.

Though the years ahead may appear opaque, they are not completely mysterious. We do not need a crystal ball to imagine what the future will bring; instead, we can turn to stories from the past as we look for guidance on how to live today. Already, a multitude of life-course data from across the globe tell the stories of the relationship between early exposures and adult disease. Evidence from the Dutch Hongerwinter, studies of diverse populations undergoing industrialization and the emerging science of toxic stress all indicate that health in childhood and adulthood are intimately intertwined.

These stories tell us that the seeds of sickness are planted early. In each of these cases, adverse health events during critical periods of development set the stage for complex, often irreversible illness in adults. They tell us that unless we are unrelenting in our quest to prevent obesity, metabolic syndrome, systemic inflammation, and asthma in children, we will undoubtedly be taking care of an even sicker set of adults in the decades ahead. They assure us that healthy habits cultivated in childhood will likely produce flourishing adolescents and adults, who will go on to give birth to healthy babies.

Our patients of all ages come to us with stories that are spoken through words, anatomy, imaging, and labs.

Each night, internal medicine wards are full of patients like Sara whose long lists of medical problems are the result of difficult lives that were side-tracked too soon. Sara’s story is the story of her young adulthood, her adolescence, her childhood and her infancy. It will come as no surprise that Sara’s childhood was riddled with anxiety and limited access to healthy foods. She was overweight by the time she began middle
school and was diagnosed with diabetes in her early twenties. She had lived an inflammatory life, and her body was inflamed as a result. We do not need a crystal ball to know what we can expect from inflamed children; our adult patients are crystal enough. They shine light on what the future will look like as long as we pay attention.

And every day, pediatric clinics welcome children like Rosie: young people whose eyes still shine while their bodies fight to keep up. We can look at these children and foresee how their lives will unfold, how their health will progress in the years ahead. It is easy to imagine Rosie developing into an obese young woman, with all of the associated complications. But we can also imagine a version of the future in which she grows taller but not heavier, in which she and her family are able to control her asthma and anxiety so that she can play, learn, and sleep. Children like Rosie still have time to grow, to change course, to lay the foundation for promising adulthoods. Our pediatric patients are made of clay; they are resilient, moldable, and far from complete.

As Med-Peds physicians, we are uniquely situated to observe the relationships between the conditions of children and the consequences for adults. While Sara and Rosie may not see themselves in each other, we Med-Peds doctors can. While the global community is preoccupied with the problems of the present, we are uniquely poised to craft a mosaic of understanding that juxtaposes past and future, that embeds crystal in clay. As a Med-Peds community, we can employ these insights to re-envision the way children grow, and the adults they will become. We need not, and cannot, wait to see what the future brings. It is not enough to imagine the future of health; instead, we must create it.

If medicine is an art, let us be sculptors rather than painters. Let us shape the health of the future instead of simply depicting the pains of the past. This will require a novel approach to clinical medicine in which patients are seen and understood as the children they were and the adults they will become. It will demand that we are innovative in how we deliver clinical care and how we collaborate with communities and governments. Luckily, we already have the materials we need: we are granted the perspective of crystals and the potential of clay.

As we proceed, we may discover crystals and clay in unexpected places. Lessons from diverse sectors and societies must be studied as we search for a better way. And while our schools, healthcare systems, and other public programs may seem sturdy, they are also pliable and are able to be changed. Our hands may get dirty, but we must do the work.

This is the time for the Med-Peds community to leverage our perspective and passion, to tell the stories that we hear and see in our patients across the lifespan. We have seen how this pandemic preys on adults with chronic diseases. We know that preventing disease means starting early. It is time for us to join forces to protect and promote the health of all children rather than simply addressing the ailments of the old. This is our opportunity and our calling. For the sake of the future, we must begin now.

Amara Finch, MD
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University of Arizona College of Medicine-Phoenix
COVID-19

The news reports trickled in, first Italy, then the Pacific North West, those were all far off places, but you could feel the energy, nervous excitement and the collective feeling of “we will rise to this”. For the first time since I began my residency three years ago at Georgetown University Hospital, I could not find a seat in the auditorium at grand rounds. One of the most respected Infectious Disease Doctors in the hospital, possibly even on the Atlantic Corridor, calmly walked us through what was coming. It was going to be bad, but the mortality rate was minor compared to influenza. Construction workers moved our workspaces in the Intensive Care Unit and placed red tape on the floor where they planned to place plexiglass walls, thus marking of the six beds that would soon become the COVID 19 bay. The plexiglass never came.

Then it hit New York, and everything changed. The red tape was forgotten, instead entire floors were dedicated to COVID 19. It was early March, 17:00 and time for sign-out. One of the ICU nurses, who are known for their calm and expert capability came rushing towards our group of doctors, “his temperature is 108F, it is not erroneous, and I cannot cool him down”. Everyone was suddenly moving and doing things, calling people and making suggestions. We were all doing what we were trained to do; assess, make a plan and put it into action. It was in those helpless moments that I realized I was not in control; I did not have a plan and most worrying neither did my seniors. The virus was not following our plans, our metrics for extubation were no longer useful, our medicines were not working.

I was called to evaluate an asthmatic on the floor, a stoic, strong-willed lady whose symptoms were not improving. I tried to calmly explain that I was concerned she may have coronavirus, that she needed to come to the ICU, that she might need a breathing tube. I asked her for her code status. I asked impossible questions of a woman who had just come to hospital with an asthma exacerbation. I asked her to make those decisions between bated breaths while alone. The anesthesiologists were now standing outside the door, waiting to intubate. I squeezed her hand tight as a tear rolled down her cheek, I promised to update her son and daughter daily and I promised to do the best I could. The next day her results came back positive for COVID 19.

The hours were long, and the shifts were busy, but the incredible sense of comradery fueled me. We were all in this together, and I was incredibly grateful that I could be a useful member of the team fighting this global disaster. Then it was April, and then May and morale was slipping. Our patients were not getting better and our census just kept growing. Our ICU grew from a census of thirty to ninety. When I walked in the door to my wonderful supportive husband each night, I could not share with him what I had been through that day, I did not have the energy to explain nor did I feel I could explain. I struggled to make it through one night-time story with my daughter before falling into bed. My sleep was fractured, and it was only those few seconds upon wakening before I remembered that COVID was real, that I felt like myself. My feet felt heavy on my short walk to the hospital each morning. I felt lost and useless.

At the start of the pandemic my mornings pre rounding were busy and exciting, now I swiped into my computer to look at worsening labs despite our new treatments. Rounds were dismal, one sad story after another. After rounds I facetimesed with family members who could not come to their dying loved one’s bedside. I called the 21-year-old woman who was now home alone and responsible for making unimaginable heart wrenching decisions; two generations of her family were in the ICU. No matter the time of day she always picked up on the first ring, I never had good news. Her thanks and praise stung. I did not want it, I did not deserve it; I was not helping.

It’s not true that time heals all wounds, but it certainly helps. I do not want to forget, but months have gone by, and each passing day has helped dull the acuity of the emotions. Each night I look forward to reading each and every book with my daughter.

Gemma Reddin
Internal Medicine-Pediatrics, PGY4
Georgetown University Hospital
I met Cassie on the very first day of my inpatient Hem/Onc rotation on a February morning. Riding on the nervous excitement that accompanied the beginning of a new rotation, I remember diligently scribbling down every single thing she told my team, my pen flying across the pages of the tiny notebook that lived in my white coat pocket. She had come in with a one-month history of, in her words, not feeling like herself. She was constantly tired, short of breath, unable to brush her teeth without her gums bleeding, and she had lost 27 pounds. Her new normal was frequent nose bleeds, little punctate bruises scattered over her arms and legs, and being unable to play with her 2 little boys at home. She could barely keep her head upright as she chatted with us that morning, and it was the first time I’d ever palpated splenomegaly during a physical exam.

The peripheral blood smear we ordered, followed by a bone marrow biopsy, confirmed a terrifying truth – numerous blast cells with Auer rods. By noon, we diagnosed her with acute myeloid leukemia.

Just like that, Cassie’s reality as she knew it was turned on its head. For the rest of the day, between seeing my other patients, chalk talks with the residents, and writing my notes, all I could think about was how Cassie was taking the news of her diagnosis. She was only 2 years older than me, I kept reminding myself. She could have been one of my classmates, a friend, my sister, me.

As my day came to an end, I stopped by Cassie’s room to see how she was doing. I am not sure what I was expecting to see when I knocked on her door, but as I walked inside, it was difficult not to notice how the number of people in her room seemed to multiply from that morning when she was all alone. Her husband was sitting next to her in bed, holding up her phone for her as they FaceTimed with their 2 children. The sofa was occupied by Cassie’s worried in-laws. A cousin was fidgeting with the window blinds. A hospital nurse from the cardiac unit, who also happened to be Cassie’s great-aunt, was dutifully checking her IV line, a force of habit.

I asked her how she was feeling. “Surprisingly okay,” she replied, a small hopeful smile on her face. “They told me I’m starting my chemo tomorrow. Something called induction therapy?” Before I could get a word in, she added, “Haven’t you been here all day? When do you get to go home?!”

I was caught off guard by the unexpected direction our conversation took, not expecting to talk about myself – especially given the kind of day Cassie just went through – but over the next 2 weeks as Cassie underwent her induction therapy, I came to learn that that’s just who she was. Caring, conscientious, and kind – things I’ve always admired in others and a standard I always strived to set for myself. We chatted every morning as I pre-rounded on my patients, our topics ranging from her symptoms to the latest drawing by her kids hanging proudly on her wall.

There were bad days, of course – the days she could barely get out of bed from the nausea and vomiting, aches in each of her limbs. But there were also the good days – and on treatment day 14, a repeat bone marrow biopsy showed no evidence of blast cells, a hopeful sign that the
leukemia was in remission. Although Cassie always smiled whenever I saw her, I noticed her smile now finally began to reach her eyes.

The next step was recovery of her cell counts before she could go home – the induction therapy had essentially obliterated her bone marrow to get rid of the cancer cells and give her a clean slate. I would read off her CBC results every morning, and as her numbers climbed up, I couldn’t help noticing how her support system grew as well. It seemed like I was meeting a new family member or friend every day, and her collection of “Get well soon!” cards on her windowsill was steadily multiplying.

In the background of all of this, COVID-19 was taking its toll, and one morning before heading to the hospital, I got an email from my school administration that students were being placed on a clinical pause and no longer allowed to go to the hospital until further notice. My heart sank as I realized this probably meant I couldn’t say goodbye to Cassie before she got discharged.

It wasn’t until a few days later that the obvious came to me at home, and I felt sheepish for not thinking of it sooner – her room had a telephone, and I could easily call up the nurse’s station to get in touch with her. Soon enough, I was on the phone with Cassie explaining the situation to her and how grateful I was for getting to be on her care team for the past month. We exchanged cell phone numbers, and I checked in with her every few weeks.

“Hi!” she exclaimed, “you made it!”

We talked for about an hour – catching up on the little things we’d missed out on in our months apart. She told me about how she and her family recently moved out of her in-laws’ house and how her sons were a joyful distraction while she had been getting consolidation therapy, awaiting the news of whether or not a stem cell transplant would be possible. We talked about how surreal it was to be living during a global pandemic, and how amidst all of it, Cassie’s cancer treatments still went on. And in her usual fashion, she made sure to ask me about how I was holding up through these “unprecedented times,” jokingly saying the overused phrase.

As of now when I’m writing this, it has been one month since Cassie got her stem cell transplant, and in her words, recovering from the transplant “has been the easiest part of all of this.” Looking
back on my experience with Cassie and being able to play a role, albeit small, in her treatment journey, I have come to appreciate how our patients can really serve as our most unexpected and meaningful teachers. Cassie had an extensive support system, whether it was her family and her friends, and aside from the morning I first met her, there was never a moment when she was alone by herself in the hospital. She was often the one who put on a strong face and comforted her family when our medical team came in to talk about her prognosis and how her treatments were progressing along. She was never afraid to advocate for herself whenever she noticed a new symptom, and she always made sure to prepare questions if she had any when our attending was there during rounds.

Not every patient, whether it be a child or an adult, is lucky to have a strong support system, and not everyone’s circumstances allow them to have a high level of resiliency as they navigate through a new and frightening diagnosis like cancer. In many ways, I am grateful that Cassie was the first patient I saw on that rotation – she helped me notice more easily when my other patients were quieter and more reserved with their questions for the team, or when it had been a few days since any visitors had come by to see them.

Though Cassie never knew it, with her help I grew more confident in speaking up as a medical student whenever I felt like my other patients could use more teaching or psychosocial support during their hospital stay. The care we give as medical providers doesn’t have to strictly be medical – especially with complex illnesses like cancer that affect more than just the patient’s body, but also their mind, their way of life, and their loved ones – and sometimes making sure that a patient has someone to thoughtfully listen to and understand their concerns is just as healing as a medication.

Upasana Chandra
Medical College of Georgia, Class of 2021
To Infinity and Beyond, Yo!
Despite the coronavirus we go!

Fans of Isaac Asimov are all too familiar with his imaginary worlds. Isolated, sparsely populated, technologically advanced, and, importantly, socially distanced beings! How strange those worlds seemed just a year ago, how familiar they seem today! Equally fictional, and in fact, the stuff of childhood for all those medical students who grew up in the 90s, is that alternate world of the fictional singer, Proto Zoa. That singer belted out the hit song, “Zoom, Zoom, Zoom... My heart goes Boom, Boom, Boom!” from the iconic Disney Channel Original Movie, Zenon of the 21st Century, that resonated through our childhood. How familiar “Zoom” has become in today’s world! Yes, the coronavirus has suddenly catapulted all of us into a surreal world, a world in which we have to scramble to get used to the new order, and make the best of a situation that was the realm of either history or fiction. Yes, that surreal, unreal world is here, and it is very much now! Thank goodness we already have the technology to deal with it! Zoom: this is one of the new tools of this new world. This is the portal that expands the world today, and makes it possible to not just make the best of the situation, but to actually go above and beyond, and to communicate with socially distant beings. But, a portal would be worth nothing by itself if it is not used well, and that is where the heroes of our story come into the picture. Enter, NMPRA and the Med-Peds Residency Programs from around the country. Like heroes in a Marvel movie, they came together, using the Zoom portal to provide the eager masses of medical students what they need at this stage of their career and during this tumultuous time. With the advent of the virus came the challenge of travel and social distancing, an especially difficult challenge faced by residency programs and prospective residency applicants. Traditionally, students could meet with programs and garner information, if not on campus, at least through open houses that provided opportunities to mingle and discuss information and opportunities. All that was no longer possible, or... was it?! Of course there was a way, and NMPRA and the Med-Peds residency programs found that way, and are using it in the best manner possible. Over the summer, hundreds of students sat in their homes, while dozens of residency programs joined in to the webinar series presented by the NMPRA. As a student seeking information about the amazing field of Med-Peds, it was great to be able to interact with so many different program directors and residency programs and to be able to gather information about programs from across the country. Residency programs used Zoom, email, Instagram, and Twitter in new and exciting ways to creatively convey information about their programs. In the blink of an eye, NMPRA program directors joined together in a united front in order to organize these webinars, and students are especially grateful to have had this opportunity over the summer. The timing was ideal, and the content was terrific. Personally, I never imagined being able to get so much information about the different residency programs in such a short time from my living room in Delaware. The webinars provided different ways to interact. There were information sessions, speakers from each residency, and the opportunity to follow up with questions both, during the webinar, as well as later through emails. It was wonderful to be able to get to know physicians, residents, fellow students, and program information. By the end of the series of webinars, it was easy to see that NMPRA had done an excellent job of organization in the midst of a crisis. It was impressive and we learned a lot just from seeing the way everything was smoothly conducted. In a matter of a few short months, NMPRA became the example for all other residency programs by demonstrating endless possibilities in an uncertain world. It was a real object lesson in the resilience of humanity in being able to find a way when the traditional routes to information had suddenly been cut off. Who would have imagined the impact a mere virus could have on all of us! This is the stuff of movies and novels, and even comic books. Yet, here we are, experiencing that fiction as a reality, and it is scary and exciting at the same time. Above all, it is proving to be a triumph of technology, one more case of mind over matter in a way we could not even have imagined a few months ago. We have been propelled into the future, and the world will be changed forever, but once the virus is behind us, these advances will remain, and continue to provide society the means to move forward at warp speed: like in a Star Wars movie!

Abhishek Surampudyidney
Sidney Kimmel Medical College, Class of 2021
Breathe (2020) by Elizabeth Hayes

I wake and take a deep breath
Grateful to feel the sun on my face
When so many others do not

I grab my mask and take a deep breath
Thankful for the gift of another day
When so many others never had one

I pass crowded restaurants on the streets
People laugh over food and my heart skips a beat
How can they laugh at a time like this?

I take a deep breath

I call an old friend
We laugh at memories and my heart mends
But how can I laugh at a time like this?

I take a deep breath

I hear reports of unfathomable numbers
I see videos of inexcusable actions
I take a breath

I cry

I wipe my tears and look to the sky

I wonder
Will we ever know justice?
Will we ever know peace?

We did not learn from the past – and so here we are
If we do not learn from this – from now – are we not destined to repeat?

I close my eyes

I breathe

Elizabeth Hayes
Howard University College of Medicine, Class of 2021
An Essay by Dr. Anish Patnaik

The following information has been edited to preserve the anonymity of the people involved.

A seven-month-old baby boy with a history of Patau Syndrome status post cardiopulmonary arrest for one hour until return of spontaneous circulation. Currently ventilated through tracheostomy. Alert and oriented, moves all extremities appropriately. Pupils are equal, round, and reactive to light and accommodation. Ears are posteriorly rotated, small, and low-set. Severe cleft lip and palate with anteverted nares. Sucking reflex was prominent. He was kinda cute. Due to the cleft lip, an unobstructed view of the mouth revealed a tongue half-sticking out, half-searching for something. Food. A mother. A connection. It made me laugh, which made you smile. It was the only time I would see your smile. The rest of the time we would only see your pain.

A camera view of the airways revealed collapsing walls. We could push air in for now to support the structure but it wouldn’t last. Your airways were rapidly progressing from the solid circular support of a metal slinky to the flaccid hollow center of overcooked penne pasta. It wouldn’t be long before you felt the insurmountable pain of deteriorating muscle tissue that accompanied an inability to breathe. Most children lived up to one year with this disease. You were going to have less. Hoping to save you from the pain, we tried to tell your parents. I wasn’t there when they were first told though. I don’t know if we went about it the best way possible. I don’t know if we sat and listened first, letting your parents express the anguish and disbelief necessary before acceptance. I don’t know if we asked what their understanding was, trying to guide and nudge them before blindsiding them with a mortality they had never associated with a child. I don’t know if we really explained what palliative care was and how there really are some things worse than death. I do, however, know what their exact response was. “We just need to take him home, then God will heal him completely.”

Although I had been breathing in second-hand Christianity my entire life, a nurse had to educate me on this particular form of ‘prosperity gospel’. You had to believe entirely in your savior in order to be saved. Any sliver of doubt, moment of wavering faith, was punishable by a withdrawal of the salvation of you and, in this situation, your loved ones. This seemed extreme to me, maybe even arrogant, but as I patiently sought understanding, I appreciated how such a perspective could be born out of your family’s circumstances.

You were from a small rural town. The kind of town where blood was not the most important feature when defining the word ‘family’. Your fathers, mothers, aunts, uncles, brothers, and sisters were all tied into a community. You were all bound by a culture that had probably been handed down for decades. That identity had now grown into multiple shades and perspectives that better mirrored the sense of individuality inculcated in the twenty-first century, but was still firmly rooted in its religious foundations. It was so easy to see how this identity had carried your family through years of trials and tribulations. How the intangible connection between the community members that was strengthened by religion had actualized itself in the form of food, comfort, and emotional support. But now those connections were coming to a head with truth. The strength and hope that religion had given your family was offset by a reality that it currently couldn’t explain nor alleviate. While your parents struggled with reconciling what could be against what currently is, you were going to be caught in the crossfire.

I talked to your mother once. She knew your pain in a way I assume only a mother can know. As she turned away from you, her eyes would glisten with liquid guilt against the sun pouring into the room.
But not a drop would fall past the steely wall of her stoicism. And behind that wall remained her religious resolve, unflinching and unforgiving. Of you and of her. I would be hard pressed to think of another moment in my life where there was such a wide schism between the sympathy and judgment that unwittingly colored every word out of my mouth. But it was obvious enough to me that she wasn’t going to make it out of this unscathed. While your scars would vanish with your body, hers would be etched into her soul for eternity. This time, I don’t know that it helped that she actually believed in that sort of thing.

Honestly though, I really couldn’t blame her. We couldn’t explain anything either. And while we might’ve been able to alleviate the pain, we certainly weren’t all knowledgeable (despite the amount of information forcibly imprinted into our brains by medical school). To give your mother the impression otherwise would be at best deceitful, at worst an unethical violation of your mothers (and subsequently, your) autonomy fed by misinformation and misrepresentation. Which begs the question, when faced with an unimaginable situation, who do you align with, the fallible and human physician, or the omnipotent, benevolent supernatural power? If you have even an inkling of hope that everything might turn out okay, wouldn’t it almost seem immoral not to go with the supernatural power? Doesn’t it seem almost villainous to give up and condemn your own child to ‘comfort care’ when a rich and fulfilling life seemed available, if only unlikely? What do probabilities matter when you’re talking about the rest of your child’s life?

As the weeks went on, your condition continued to worsen. The percentage of your blood that carried oxygen, typically 95-99% in most people, was regularly in the seventies. Every time we passed by your room for rounds, a slow-moving fog of depression would creep over the team. One time it got to me as I was presenting your situation to the team. My voice, typically active and motivated during a presentation, sluggishly trickled off until finally, exasperated, I asked, “what are we doing for him?” What would’ve otherwise been an unacceptable breach of professionalism was tacitly forgiven by the team and my fellow quietly responded, “I don’t know.” I continued on with my presentation, because you were continuing on as well.

Your parents stopped visiting as much. Someone used to be here everyday, but that slipped into every other day, and then a few times a week. Your siblings were home-schooled and your hometown was a long drive away. They had other responsibilities. Some of us, myself included, were indignant. You force this pain and suffering on him and then leave us to witness it? It seemed unfair that we were left to endure the moral injury of another person’s decisions. But as soon as someone would take one look at you, they would’ve understood. Your toes started looking blue. You could hear gasps of air from your room during the worst parts. It was eerily unnatural to hear that noise from a baby. We had all heard weird noises from babies, after all, you can’t step one foot into a children’s hospital without hearing a bronchiolitic cough. But this was different. It was unsettling. When you heard that noise, there were no more questions about why it was difficult to show up. They didn’t ask to have a child like this. They didn’t sign up to care for a child like this. We did. People seek to become nurses, PAs, NPs, and physicians because they want to help people, but few actually realize that entails being the pallbearer of another person’s suffering. Fewer are capable of handling it. So most end up trying to find a cushy corner of their profession such as dermatology where they can hide from it. You can’t blame them, just like you can’t blame these parents.

You started coding frequently. Your oxygen saturation would drop into the teens. I had legitimately never seen it drop that low in a living person. I didn’t even realize it was possible. Per your
family’s wishes, we initiated life saving procedures and began pushing more oxygen into your lungs. While that is a very simplistic description of what was done, it also accurately convey the risks. Too much oxygen, and you cause long term oxidative damage to the lungs. Too much pressure, and you risk blowing a hole open in the lungs, also known as a pneumothorax. The pressure required to bring you the amount of oxygen bound in your blood just to the fifties needed at least 40-45 mmHg of pressure. I realized we were toe-ing a thin line. “What’s worse,” I asked the fellow, “suffocating slowly to your death, or dying quickly but painfully?” The fellow was quiet. “I don’t know.” Yeah, me neither. We continued delivering the high pressure until you recovered.

The last two days or so you were gasping with every breath, trying to feel a fullness we all knew you’d never find again. The blueish hue that was contained to your toes, fingers, and mouth was starting to spread. You didn’t move as much anymore but your head would sway back and forth as your brain felt the confusion and pain of oxygen deprivation. You died early in the morning. A solemn mood overtook the little corner of the pediatric ICU that had grown accustomed to your presence. We were all relieved that your suffering had finally abated, but we still felt that sense of inexplicable loss when a connection you once had with someone has left you. Some of the nurses took turns holding you. I said a quaint, unimportant goodbye. After all, I was just the medical student. But we all did our best to be with you as much as we could, which is a privilege I will always do my best to treasure and honor as a physician.

Your parents didn’t come that first day. The look on some of our faces betrayed the sense of indignation that was hidden behind the wall of professionalism that our words would never break through. I felt the same way. As I went about my day, it was hard to not wonder where they were. While I knew they had other responsibilities and concerns, it was increasingly hard to remember as my day went on. But it wasn’t really about the responsibilities or concerns. As I took the staircase between floors to head back to the student lounge, I lingered at the window, as I’ve done in the past. The pediatric hospital had vertically continuous windows at each corner staircase. From the tenth floor, the windows overlooked a beautiful park that was bound by the downtown rail on the left and the zoo on the right. As my eyes caught the playground, I saw the strangest thing. Parents were playing with their children on the jungle gym. Parents were walking with their kids, hand in hand, along the trail. Parents were pointing out the ducks at the pond to their wide-eyed young, who were reveling in this new and wondrous experience. Parents were being… parents.

That’s something your parents never got to do with you. And I’m not saying this to absolve them of their responsibility, but just to point out the stark difference between their expectations and their reality. If it was jarring to me, someone in healthcare, just to watch parents take their kids to the park, I couldn’t possibly imagine what it was like for them. This reality was never something they could even fathom. They might not have even known that it could exist. Sure when they decided to become your parents, they took on some responsibility for an uncertain future, but how likely is it that this kind of future was in the purview of their understanding? Was it even in mine when I had decided to become a doctor?

Anish Patnaik
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Advice to Rising Second Year Med-Peds Residents,

I walked into the Cardiology workroom 45 minutes early, eagerly ready to receive sign-out as I was set to begin my first night as an upper level resident. Despite the challenges of intern year, I was always able to consistently perform well and troubleshoot complex medical and social problems. In my head I would think, “this should be no different as an upper level!” I had spent the week prior completing my intern year in the Pediatric hospital and couldn’t wait to step into my new role. Little did I know that I was about to start the most difficult shift thus far in my residency. I never would have guessed how defeated I would feel 12 hours later as my intern and I completed 6 admissions, had one unexpected death, and tried to keep critically ill CICU patients alive. I had hoped to teach my new intern the logistics of admitting, how to manage someone with chest pain, and how to write a good H&P. Instead I found myself not able to teach anything but rather my new intern learned from the “hidden curriculum” as I stumbled through a rapid response, as I called to tell a wife her husband had unexpectedly died, and how to fill out a death packet.

Up until that night, I had never questioned my decision to pursue training in a combined Med-Peds residency. I began to think how woefully unprepared I was to be an upper level on either the adult or pediatric hospital. At that point in time I had only 7 months of experience compared to the categorical residents who had 13 months. How could I possibly hope to be a competent practitioner on both sides with only four years of training? Although it was difficult, I continued with my second year that was riddled with moments that exposed knowledge gaps, frustration, and feelings of inadequacy. A quote I came across in The Humans of New York series gave me solace as it discussed what to do when life becomes difficult:

“There’s three things you can do when life sends a wave at you. You can run from it, but then it’s going to catch up and knock you down. You can also fall back on your ego and try to stand your ground, but then it’s still going to clobber you. Or you can use it as an opportunity to go deep, and transform yourself to match the circumstances. And that’s how you get through the wave.”

I frequently reminded myself of this quote and tried to “go deep” every opportunity I could whether it be trying to lead rounds on the medicine wards or discussing treatment plans in the PICU. Eventually, with determination and the help of my Med-Peds family, my daily struggles began to ease and my confidence in being an upper level grew. Soon I found myself equipped to solve unique problems and offer different viewpoints in terms of medical management by drawing on my combined knowledge.

Even now as a rising third year, I still think about that night and consider it the most humbling experience of my life. To all the new Med-Peds second years, residency doesn’t get any easier, but you will become better equipped to handle those difficult situations. As you go through your training, lean on your Med-Peds co-residents. Many, if not all, experience the same struggles that are brought on by the unique nature of our training in a Med-Peds residency. Work hard every day and don’t forget to “go deep”.

Biren Desai
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Initiation of transitional coaching during an inpatient admission

Authors

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Intro:

Chronic disease is extremely prevalent in the adolescent population and between 7-14\% of adolescents live with a chronic disease.\textsuperscript{1} A study in 2011 concluded that although survivors of childhood disease had similar rates of marriage and becoming parents as those who did not suffer from childhood disease, they had a significantly lower rate of graduating college and had a lower mean income.\textsuperscript{2} In our case, we highlight the importance of identifying early adolescence as a period during which chronic disease management may be shaped. In particular, we highlight the importance of using inpatient admissions as a “critical point” for performing transitional coaching.

Case description:

We present the case of an 11 year old girl with a past medical history significant for pancreatic failure status post pancreatectomy, splenectomy and cholecystectomy who is now status post islet cell transplant six months prior who presents with severe hyperglycemia and ketosis without acidosis. She was admitted given concerns of infection in the setting of splenectomy and was started on intravenous fluid administration and insulin to target euvolemia and normoglycemia (defined as blood glucose of 140mg/dL-180mg/dL), respectively. She was covered with empiric antibiotics. After initial fluid resuscitation, she appeared to be clinically improved and she remained well appearing until discharge. A thorough interview was significant for a complex social history including history of sexual assault, gender dysphoria, and a recent diagnosis of cervical cancer in her mother. Ultimately, we determined the likely etiology of hyperglycemia to be poor adherence to medication in the setting of numerous social triggers and peri-adolescence. We chose to use this admission as an opportunity to begin transitional coaching and the patient was discharged with follow-up in our adolescent and endocrinology clinics.

Discussion:

For our patient, it was clear that there were numerous social stressors playing into her illness. While the basic treatment of her diabetes was obvious to identify (replace the lack of endogenous insulin with exogenous insulin), the practical management of her disease was much more complex. After an initial discussion with the mother and patient, it was clear that the mother was deeply caring and protective. It was also clear that this protectiveness was preventing the patient from learning to take ownership of her disease. While the system the family had set up was initially successful in managing the patient’s diabetes, the recent diagnosis of stage IV cervical cancer complicated treatment.
We approached treatment by talking directly to our patient instead of her mother. We were sure to include the mother in discussion but we geared all discussion towards giving the patient ownership over her health. The mother expressed disinterest in seeing a diabetic educator because she herself had poor experiences in the past. However, we framed the diabetes education as an intervention not for her, but rather for the patient herself. We gave the patient the option of having her mother sit in on the education and made it clear that the education was primarily for her. We encouraged her to check her own blood glucose, calculate her own insulin requirements and perform her own injections at each meal and at bedtime. To further help our patient understand her illness, we first assessed her understanding of her illness. Then we explained in basic terms what diabetes is, what insulin does and why maintaining proper sugars are important. At the end of the discussion we had the patient “teach back” what we had explained and she reciprocated a thorough understanding of her medical history as well as her current treatment plan. At the time of discharge, our patient’s apprehension and reluctance to manage her own health had partially improved and she was given close follow up at our adolescent and endocrinology clinics to continue her transitional coaching.

**Conclusion:**

We successfully initiated transitional coaching in the inpatient setting. We believe that these vulnerable periods during adolescence can be framed as positive experiences for patients during which the management of chronic disease can be shaped. Ultimately, we believe that by initiating transitional coaching early in the course of chronic disease we can improve social and potentially medical outcomes of chronic disease in adulthood.

**Key Lessons:**

1. Chronic diseases that start in childhood can impact patients in adulthood.

2. Adolescence is a period of growing and change and can be a pivotal time to shape how chronic disease is managed.

3. Inpatient admissions present opportunities to initiate transitional coaching.

**References:**


How early is too early? An 18-year-old female with diabetic end stage renal disease presenting with dysarthria and left sided weakness.

Authors

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1. UPR Pediatrics Residency
2. UPR Medicine-Pediatrics Residency

Intro:

Historically, ischemic stroke (IS) is an uncommon diagnosis among adolescents and young adults when compared to older population. Congenital heart disease and cerebral arteriopathy account for the majority of cases, most of which tend to recur and convey poor prognosis. Diabetes and End stage renal disease (ESRD) are worldwide, the most common predisposing risk factors for cardiovascular complications such as ischemic stroke\(^{1,2}\). Neurologic complications from diabetes in pediatric patients are rare but they have been increasing in incidence for the past decades and most commonly in patients with poor glycemic control\(^3\).

Case description:

This is the case of an 18-year-old female with poorly controlled type 1 diabetes (T1D), stage IV chronic kidney disease (CKD) and secondary hypertension with insulin and long-acting nifedipine therapy at home. Medical history is relevant for poor patient compliance and several visits to the emergency department (ED) due to acute diabetes complications. The patient developed dizziness and fatigue for the previous 3 days and slurred speech with left sided weakness within the last 24 hours, for which she was taken to the ED. Computed tomography (CT) without contrast showed hypodensity of the corpus callosum with a large callosal infarct. She was transferred to this institution (Pediatric University Hospital) for higher level of care – Pediatric Intensive Care Unit. On admission physical findings were unchanged from previously described. Laboratory findings were remarkable for severe anemia 4.8g/dl, leukocytosis 14.7x10\(^3\), severe symptomatic hypoglycemia 29mg/dl and a small number of ketones in plasma without meeting diabetic ketoacidosis criteria, however\(^4\). Magnetic resonance imaging (MRI) showed restricted diffusion and a small punctate hemorrhage at the corpus callosum, which would be re-demonstrated within a week, with a contrasted adding abnormal signal intensity and mild expansion to the previous finding. Given the uncommon diagnosis of ischemic stroke in children, several differential diagnoses were explored including a lumbar puncture which was negative for autoantibodies, infection and malignancy. Numerous other etiologies such as vasculideties (moyamoya, primary angiitis of the central nervous system), autoimmune conditions (systemic lupus erythematosus, autoimmune encephalitis, posterior reversible encephalopathy) (PRES), coagulopathies (Protein C & S deficiency) and cardioembolic etiologies (grossly normal echocardiogram), among others were all negative. Conservative management showed neurological improvement over the next week returning almost completely back to baseline, with the exception of the left sided weakness.

Discussion:

Diabetes and hypertension account for the majority of ischemic strokes in the adult population with extremely high prevalence among patients on hemodialysis, in contrast to pediatric patients where it becomes a rule out diagnosis.\(^5\) The purpose of this clinical vignette is to highlight the increasing incidence of diabetes related cerebrovascular accidents in younger individuals,
especially those diagnosed at a very young age, such as this patient who was diagnosed at one year of age. As noted above, the patient already developed microvascular complications of diabetes, nephropathy (Stage IV CKD) and neuropathy with foot drop.

**Conclusion:**

Current evidence supports the beneficial role of intensive diabetes therapy against microvascular complications and long-term beneficial effects on the incidence of cardiovascular disease in T1D that persist for up to 30 years.\(^6\)\(^7\) Despite groundbreaking advancements such as synthetic insulin and newer antidiabetics, patient adherence remains the major determinant to develop chronic diabetic complications especially among adolescents and young adults and lower socioeconomic status\(^8\). According to current literature, the rate at which they are developing is unprecedented.\(^9\)

**Key Lessons:**

1. Cerebrovascular events are increasingly more common in younger patients with T1D.
2. Intensive management of T1D results in long-lasting benefits in regards to preventing microvascular complications and cardiovascular disease.
3. Patient adherence is one factor that affects progression of diabetes and subsequent complications, a factor that can should be modified in our younger population.

**References:**

A Case of New Onset T2DM Complicated by Severe Mixed DKA/HHS and Features of Fatal Malignant Hyperthermia-like Syndrome in Adolescent Male

Authors

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Introduction:
This is the case of a 15-year-old male who presented with newly diagnosed T2DM found to be in mixed DKA/HHS state with subsequent development of refractory shock, ECMO dependence, and ultimately death. The patient’s mixed presentation with concurrent DKA and HHS features and lack of widespread defined Pediatric Intensive Care Unit protocols to manage patients with concomitant features of both processes must be considered when assessing factors contributing to his death. This issue is of importance as the prevalence of T2DM increases dramatically in the pediatric population and requires further research to define protocols in similar patients. Medicine-Pediatric providers are uniquely equipped to be involved in the development of said protocols due to their expertise in treating both conditions across the age spectrum.

Case Report:
The patient is a 15-year-old obese African American male with no prior past medical history who presented to the pediatric ED with a 1-week history of nausea/vomiting, increased thirst, and fatigue with progression to worsening AMS, found to have blood glucose reading of >600 in ED triage. Initial VBG 6.97/27/361/6.2/Lactate 4.7. He received 1L NS bolus (~8cc/kg) in the ED and was admitted to PICU for ongoing care within 1 hour of hospital arrival. New onset DM labs obtained in ED subsequently notable for Serum Glucose 1624, A1C 11.9%, C-Peptide 2.7 ng/mL (normal 0.7-3.9), Insulin level 15 uIU/mL (normal 3-25), BHB 11.28 mmol/L, Serum Osm 395 mOsm/kg, GAD65/IA-2 Ab/Insulin Ab negative, most consistent with new onset T2DM diagnosis with concurrent HHS and DKA features.

Within his first 12 hours in the PICU, blood glucose only marginally improved from 1600→1400, corrected serum sodium increased 141→156, and patient developed worsening mental status. Upon review of initial resuscitation efforts, he was documented as net positive only ~200cc during that 12 hour timeframe. Patient ultimately became febrile with subsequent seizure-like activity, concern for rhabdomyolysis (peak CK 3106 U/L), and inability to protect airway requiring intubation. As patient was admitted during COVID-19 epidemic, COVID PCR was sent and negative. Head CT performed with evidence of diffuse cerebral edema without herniation. Patient ultimately had Vfib arrest with achievement of ROSC and cannulation for VA ECMO. Patient managed on ECMO for approximately 12 hours with worsening clinical status and multisystem organ failure. Family ultimately decided to withdraw care, and patient died approximately 36 hours after initial presentation.

Discussion:
Recent data from the US CDC has shown that T2DM in youth has increased dramatically over the past several decades, with recent estimates suggesting an incidence of ~5000 new cases annually with further projected increase in incidence by 2.3% annually\(^1\). Based on this data, it is inevitable that pediatric providers will continue to be confronted with the management of T2DM, both in the
outpatient and inpatient/critical care settings. Unfortunately, many pediatric providers lack the comfort and expertise necessary to recognize and manage T2DM as a discrete entity from T1DM. In the patient described above, he was treated largely based on a T1DM DKA protocol with inadequate fluid resuscitation efforts to account for the significant fluid losses and profound elevation of serum osmolality on presentation. Furthermore, there have been case reports in obese adolescent African American males with new onset T2DM and HHS presenting with a malignant hyperthermia-like syndrome that shares many features with this patient’s clinical course, the pathophysiology of which remains poorly understood\textsuperscript{2,3}.

**Conclusion:**
This patient’s tragic outcome highlights the urgent need for further research regarding the management of HHS or mixed DKA/HHS in pediatric populations, an entity with unique features and complications (i.e. malignant hyperthermia-like syndrome) from that observed in the adult population. Medicine-Pediatric providers are uniquely trained to contribute to the establishment of evidence-based protocols to manage T2DM in pediatric patients and prevent recurrent outcomes like the patient presented in this case.

**Sources:**
Med-Peds means bringing a unique perspective to each team.

Med-Peds means having the freedom to explore a wide variety of careers.

Med-Peds sometimes means long hours and racing hearts.

Med-Peds means family.

Cathy Cichon, MD, MPH
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