Med Peds Celebrates 50 Years

Please join us in wishing Med-Peds a happy 50th birthday! 2017 will be a year of celebrations across the country - from regional meetings to the Med-Peds program director meeting to the party of the year - the NMPRA and AAP national conferences! We hope that attendings, residents, and medical students from across the country will join us September 16-17, 2017 in Chicago for a great weekend of speakers, comradery and of course celebrations! We promise fun for all and lots of entertainment to be announced in the coming weeks. Please mark your calendar and encourage your colleagues to join us!

Second Annual NMPRA Community Service Day

The 2nd Annual NMPRA Community Service Day will be held on Saturday, March 4, 2017. The purpose of this event is to unite Med-Peds programs across the country so that, despite our geographical distance, we can all come together on the same day to positively influence the lives of people living in our local communities. In the past, residents, faculty, and students have worked together to volunteer at local food banks and soup kitchens, work in community gardens, and organize food/clothing drives. This year we will be hosting a competition to see which residency program can have the greatest impact on its local community with the smallest ecological footprint. The top three winning programs will be featured on the NMPRA website and will earn bragging rights for an entire year! Remember that, no matter how big or small, our efforts do make a difference, so please encourage participation! Have lots of fun, and email any questions, concerns, stories, and photographs to outreach@medpeds.org. Happy serving!

NMPRA Midwest Regional Meeting

When: Saturday, April 8, 2017 from 9am to 4pm
Hosted by: Ohio State University & Nationwide Children’s Hospital, Columbus, OH
Theme: A Tale of Two Departments: The nuts and bolts of finding your ideal combined Med-Peds job
Audience: Medical students, residents, attendings and anyone interested in Med-Peds
Registration to open soon!
Happy New Year.

In the beginnings of 2017, I am mindful of three important transitions.

First, since I just was fortunate to become Chair of the AAP Section on Med-Peds, I want to take this time to express my continuing gratitude to my predecessor, friend, and colleague - Allen Friedland. For those of you who haven’t met him, it is incredible to see the unbridled enthusiasm and untiring dedication with which he has served all things Med-Peds over the years. As a group we thank him for this and ask that he continue to push the important issues that are important to our community.

He is currently a leader in the group planning the celebration of the 50th year of Med-Peds as a specialty in Chicago on Saturday and Sunday, September 16-17, 2017. More to follow on this later, but it will be a great way to celebrate our kinship of being dual trained specialists.

The second major transition is more obvious since I work in Washington D.C., and Inauguration Day was January 20th. As the political winds change and there is talk yet again of major changes in the way medicine is practiced and paid for in this country, and how the science of medicine and vaccines are interpreted, the Section will continue to monitor and advocate for the interests of Med-Peds physicians. Through our colleagues at AAP, ACP, and other partner organizations, we will continue to look at how practice changes, how we maintain certification, and how we are paid.

The third is not a true transition, but it is about patient transition, a common focus of our group. We have recently seen several books by Med-Peds authors, one on the Care of Adults with Chronic Childhood Conditions, A Practical Guide, which was edited by Pilapel et al, and has chapters authored by many members of our community. The other, Hospital Medicine: Perspectives, Practices and Professional Development, by Habicht and Gulati. This, in conjunction with numerous journal articles from our own authors, make me proud that we are contributing to the science and practice of medicine.

I am proud of what we do as community, and how closely the three major organizations representing trainees, program directors, and practitioners work together. I look forward to continued collaboration with all of you, and hope to see you in September in Chicago.

Thanks,

Mike Donnelly, MD, FAAP, FACP
Chair, Med-Peds Section, American Academy of Pediatrics
Dear Good Colleagues,

Greetings in the New Year! We have entered our 50th year as an official combined specialty. We have become middle-aged – and we look fabulous.

While our programs tend to be smaller than our straight peds or medicine colleagues, our footprint is often larger than our numbers would suggest. Maybe our smaller programs make us nimble. Maybe it is a way of thinking. Maybe it is because we work collaboratively across all departments, all terrains. But, we are often at the forefront of innovation. Our national MPPDA meeting this year promises to highlight our unique role in medical education and at our institutions. Get psyched.

Here is to the next 50!

Happy New Year to all,
Benjamin Doolittle
MPPDA President

PS: Thanks Allen Friedland for commissioning the cool logo!

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The Med Peds Program Directors association has offered two awards in recent years – The Walter Tunnessen Award given to a graduating 4th year resident and the Med Peds Leadership Award given to a senior most leader in the med-peds community. This year, at our national meeting, we will inaugurate the Brendan Kelly Award to honor the very best of our Associate Program Directors. Dr Brendan Kelly was a dear friend who died unexpectedly this past summer. As the APD at Baystate for 18 years, he was a skilled and beloved physician and teacher, earning 19 medical student teaching awards in his career. This award is given to an Associate Program Director who demonstrates teaching excellence, collaborative leadership, and compassionate patient care that Dr. Kelly modeled so well. Nominations have been received and MPPDA will announce the winner at this spring’s national meeting.
Dear Med-Peds Colleagues,

As you know we do not charge membership dues to be a member of the Med-Peds section. We do that for several reasons but the most important one is that we realize that many of you have multiple dues obligations to various organizations besides the AAP, such as the ACP or various other primary care and specialty organizations. Our goal is to keep you all in our fold and try and represent the “Med-Peds” community. However, we do have expenses and are trying to get more Med-Peds residents involved and at our national meeting through the poster competition so that they stay in the section upon graduation.

In 2017, the profession of Med-Peds turns 50! We’re asking those of you that are able, to please consider donating $50 (more or less depending on what you can afford) and join our “50 Year” club in honor of nearly 50 years of Med-Peds experiences. Unlike a dues request, this is a 100% tax-deductible donation. With your donation, we can continue to support our resident membership with the 2 poster presentations and hopefully fund even more great initiatives including continued work with physician wellness, 50th year celebrations, and more.

Thank you for supporting Med-Peds!

Michael Donnelly, MD, FACP, FAAP
Allen Friedland, MD, FACP, FAAP
Jayne Barr, MD, FACP, FAAP
Samuel Borden, MD, FACP, FAAP
Richard Wardrop, MD, PhD, FACP, FAAP
Jennifer Gerardin, MD, FAAP
Michael Mandarano, DO, MS

NMPRA Advocacy Update

It has been quite a tumultuous past few months in the world of policy and politics. The next few months promise to be just as interesting. We are expecting to see major changes to the laws governing the nation’s healthcare system with this new administration which has majorities in both houses of Congress.

Over the next few months some of the major topics that will be debated in Washington include the Affordable Care Act, abortion, medication pricing, and marijuana legalization. There are also very pertinent issues that are being debated in the sphere of medicine including pediatric hospitalist certification, resident duty hours, physician suicide, and maintenance of certification. Regardless of where your opinions on these issues fall, there is no more important time than now to be informed and get involved.

NMPRA will be hosting a legislative day on the hill to address some of these issues with our representatives. Be on the lookout for more information!

If you have any questions about NMPRA’s advocacy efforts please contact advocacy@medpeds.org

NMPRA Professional Development Update

As part of the ongoing mission to promote opportunities within the Med-Peds community we are initiating 2 mentorship programs. We have already initiated a student—resident program. For more information on this, contact communications@medpeds.org. We are now launching a resident-attending mentorship program aimed to help Med-Peds residents connect with advanced trainees and attending physicians in Medicine-Pediatrics. We are hoping to provide mentoring opportunities in all regions of the country and across subspecialty rotations. Please email advancement@medpeds.org if you are a resident interested in developing a mentorship relationship and let us know what your interests are (region, big city vs rural, specialty, practice setting, etc). We can provide the contact for some of our Med-Peds trained physicians who are interested in mentoring or help find someone that can provide what you are looking for. For opportunities/mentoring in our combined training programs, please check out our combined fellowship guide at https://medpeds.org/residents/fellowship-guide/.
Ivy + Bean...and the Measles

As a follow-up to the 2014 launch, the American Academy of Pediatrics (AAP), Measles & Rubella Initiative (M&RI), and other partners have introduced a new set of educational materials, featuring the precocious duo, now available for doctors, schools, child care centers, and other child health providers. The resources, designed by children’s illustrator, Sophie Blackall, feature her popular characters, Ivy and Bean, as they try to stop the measles!

Each kit, available in English and Spanish, includes posters, coloring comic books, stickers, and temporary tattoos. The resources are free of charge (including delivery) and are only available for a limited time. Join Ivy and Bean on their crusade to stop measles by ordering your resources today! (Limit 2 per order; available in US only; must create a log-in account to place and track order).

Click here to order.

High Value Care: New Transitions of Care Toolkit

A new Transitions of Care Toolkit designed to assist physicians in transitioning patients from pediatric care to an adult primary or specialty setting of care is now available. Developed by the American College of Physicians (ACP) Council of Subspecialty Societies, with participation from the American Academy of Pediatrics (AAP), multiple medical specialty groups and patient advocacy organizations, the toolkit contains disease/condition-specific tools developed to assist physicians in transitioning young adults with chronic diseases/conditions into adult care settings. Based on the clinical report, “Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home,” from the AAP, ACP, and American Academy of Family Physicians, the National Health Care Transition Center/Got Transition developed an evidence-informed model, the Six Core Elements of Health Care Transition, which includes free sample tools clinicians can download and implement in their offices. These core elements were used as a basis for the development of the Transitions of Care Toolkit. Click here for more information and to access the Transitions of Care Toolkit.

Save the date

**Joint CME Course: Section on Med-Peds and Section on Adolescent Health**
February 9-12, 2017, Disney’s Grand Californian Anaheim, CA
Register today at shop.aap.org/adolescent2017

**American College of Physicians**
March 30-April 1, 2017, San Diego, CA
https://im2017.acponline.org/

**American Academy of Pediatrics National Conference**
September 16-19, 2017, Chicago, IL
http://aapexperience.org/
Transitional Care in Resource Poor Settings

When I stepped off the tarmac into the warm humid air at the Kotoka airport in Accra, Ghana in October, the smell of burning rubbish filled the air, the faint sound of beating drums, and the huge “Akwaaba” sign greeted me in the most recognizable way. I reminisced back to that same step nine years prior - that same tarmac had given me a sense of adventure, unsteadiness and wonder as I entered out unto a world of unknown.

Now, when I step off the plane - the smells and sounds are familiar and comforting. I feel at home, and privileged to have the opportunity to continue to return to a place where I feel so connected.

When I first started working in Ghana before medical school, for Ghana Health and Education Initiative (GHEI) as the Health Programs Coordinator (HPC), it was the children in the village that I found myself relating to across what I had initially thought to be insurmountable odds. Despite being triple their age, growing up thousands of miles away, and with seemingly unrelatable previous life experience - our understanding and ability to care for each other was undeniable.

It was not long after moving to Ghana that I learned of one of our Community Health Worker’s daughter who was diagnosed with Tetralogy of Fallot for whom she was trying to raise thousands of dollars for her repair. Shortly thereafter while touring one of the large teaching hospitals in Ghana, I was serendipitously introduced to a pediatric cardiothoracic surgical mission from Boston Children’s Hospital. From that day on, we worked hard to create a streamline referral network from our region to their team, which included our staff member’s daughter.

As I have transformed from a pre-clinical to a medical student and now a senior Med/Peds resident, it has been a humbling experience to grow up in my career along side these resilient children as they thrive after intra-cardiac surgery. I first met most of them in a purely non-clinical role; playing games on our cement stoop late at night, reading to them in the library or doing health education with their parents in clinic. My role in Ghana naturally progressed during medical school and residency, from health education to health care provision. As my understanding of their complex medical conditions deepened, so did our relationships and my ability to question and advocate for their health. It has been an honor to wear my Med/Peds hat as these pediatric patients are now transitioning to adult medicine. We are discussing contraceptive counseling given their potential for high-risk pregnancies and the importance of increased health care self-efficacy as a young adults with pertinent past medical history.

When I was applying to Med-Peds residency, I knew I wanted to combine my worlds: bring together my passion for pediatric to adult transitional care within a resource limited setting. I feel so fortunate to have been able to continue do the work I am so passionate about, and support two NGOs with respectable missions such as GHEI and Ghana Hearts and Minds at Boston Children’s Hospital. Even more so, I feel thankful for these children, who are now beautiful young adults who have allowed me to grow and learn from them over the last nine years through my own and continued transition.

Leah Ratner, MD, MS PGY3
Internal Medicine & Pediatrics
Medstar Georgetown University Hospital

News release after October mission can be found here: https://gheiblog.wordpress.com/2016/06/03/a-visit-from-boston-childrens-hospital
Learning, Understanding, and Creating Quality Improvement Projects as a Residency Program

This January, while the city of Washington D.C. prepares for large changes in the political landscape with the inauguration of a new president, our Internal Medicine and Pediatrics program at Medstar Georgetown University Hospital took a different approach to making changes at home. Two years ago was the beginning of a one week quality improvement initiative that provided residents time to create projects focused on areas of improvement in the outpatient clinic. Over the course of these two years, this dedicated time has evolved into much more than a protected block to develop our ideas. It is now a rotation that teaches the attributes of high impact and sustainable quality improvement projects, how to develop interventions both at home and abroad, and finally, provides individuals an opportunity to reflect upon their career to date and their future goals.

Projects were developed by a team of two residents (PGY-1 paired with PGY-3 residents and PGY-2 with PGY-4 residents) along with one faculty mentor. Projects this year have ranged from improvement of inhaler use in asthmatics to identification of co-morbidities among patients with end stage renal disease. During the course of this now two-week period, residents received lectures from topics such as the basics of evidence based medicine, bioinformatics, safety reporting, and general project design. In addition, interspersed throughout the week were global health lectures to bring variation, for example a lecture entitled, "Fever in a Returning Traveler". At the beginning of the second week, each team presented their preliminary work to the program’s residents and attendings to receive feedback and provide constructive suggestions for each project as it progresses. By the end of the rotation, each team had a solid framework for their project in place with the goal of continuing their work to completion over the next few months.

Given the fact that this rotation allowed for all residents to be together for one long stretch of time, it was a unique opportunity to spend time with one another as a whole program. A few of the group activities outside the realm of academia included packaging food for the homeless, a holiday gift exchange, morning spinning classes, hot yoga sessions, team building exercises at a retreat in Maryland, and even a weekend cabin ski trip three hours north of the city. However, as I come to the end of my residency career, I believe one of the most valuable aspects of this time together was the ability to work side-by-side with the junior members of this program. Watching the sheer enthusiasm the junior residents displayed for their projects in combination with the senior residents willingness to impart knowledge and guidance was a special scene that I cannot fully put to words.

This rotation, coming at the midpoint of the academic year, was a demonstration to all the residents that you can juggle many obligations at one time from attending lectures, helping the community, having a life outside the hospital, and finally the creation of a quality improvement project that one is proud to say they developed.

Alan Nyquist, M.D
Chief Resident, PGY-4
Internal Medicine & Pediatrics
Medstar Georgetown University Hospital
The Rollercoaster of Intern Year

“Quick! I need a doctor by bed 10, and you’re the only one around!” – It took me a moment to process her statement, was she talking to me? The new intern? My heart began to race at a million miles per minute, as I ran over to the patient’s bedside. It was my first weekend on call in the NICU, 30 patients deep, and my sickest infant, on an oscillator, had self-extubated. The attending and NICU fellow had been pulled for an urgent evaluation in the delivery room, and I was the only physician around. Nurses had been attempting to ventilate via bag-valve mask, but the infant continued to decompensate nonetheless. Immediately I was handed the MAC blade, and a wave of confidence came upon me. Although my body was shaking, I comfortably positioned myself, opened the mouth, got a view of the cords, and intubated. My attending and fellow ran in as we were auscultating breath sounds, and thankfully the tube was well positioned. His vitals began to normalize, and he appeared more comfortable. Just like that I had intubated my first premature infant.

It’s hard to believe six whole months of intern year have passed. Feels like just yesterday, I was filled with the anxiety and fear of the unknown. Would I match, let alone to my preferred program? Would all the years, money, and effort go to waste? The escalating anxiety quickly faded into the excitement and relief of Match Day, knowing that I officially belonged to the Med-Peds family. Although most of us are elated on that big day in March, the truth is, the anxiety never completely dissipates. It proceeded to take on a new form as I began to question my potential, my competency, my knowledge, and my credibility, in comparison to my well accomplished colleagues. This was a new level of anxiety, as it was no longer a matter of performance on an examination, but rather a matter of medical decision making, determining patient outcomes. Fortunately, my Med-Peds colleagues and mentors have helped ease my angst tremendously by placing everything into perspective. With each passing day, I came to realize that the patient responsibility which initially was a source of pure anxiety, was the very source that thrilled and motivated me unlike anything else. Having the privilege of decision making as a resident and taking charge of my own patients gave me an unparalleled sense of fulfillment. It was ultimately what I had worked so hard to attain. Regardless of how frustrating or overwhelming things may become, I am constantly reminded of the honor to have such a significant influence on patient’s lives during their most vulnerable moments.

As I have progressed through intern year, and reflected upon my growth, I’ve realized that my experiences on internal medicine rotations have helped with pediatrics and vice versa. The only reason I felt confident enough to intubate the ex-29 week infant, was because I had experience intubating many adults previously. Although a very different population and technique, I knew the important steps to take, and could apply them in a unique situation. I felt more comfortable than I expected in the delivery room, because I had experiences with codes in the adult CICU. Although NRP is very different from ACLS, both are systematic approaches to a crashing patient. In many ways, this illustrates the unique journey of a Med-Peds trained physician, being able to apply experiences of one patient population to another, and contributing a different perspective. Life is full of transitions, but there’s no need to tell that to Med Peds people! The transition from medicine to pediatrics, from intern to senior resident, all can be quite challenging and even daunting. Though what I came to realize is – a little anxiety isn’t always a bad thing. Constantly being thrown out of my comfort zone, has pushed me to become a more efficient and competent provider, faster than I ever imagined. It was naive to think that all my anxiety would dissolve with the climax of Match Day, but my Med-Peds colleagues and mentors have taught me how to make it constructive and how to improve each day for the benefit of my patients. It is remarkable how much growth can come from persistent curiosity and taking things one day at a time. I never thought I’d be saying this in January of intern year, but residency is truly awesome and I can’t wait to see what the rest of the year brings!

Valien Kondos, PGY-1
Internal Medicine & Pediatrics
Christiana Care Health System
Spicing up the Differential for Diffuse Alveolar Hemorrhage

Katherine Alexandra Despotes, MD, Emily Ciccone, MD, MHS and Dr. Richard M. Wardrop III, MD, PhD
University of North Carolina, Chapel Hill, NC

Introduction
Hemoptysis with respiratory compromise is a potentially life threatening condition. The differential diagnosis of this clinical condition is broad but swift recognition and identification of its potential causes is vital to initiating appropriate treatment (Park MS). Here we report a case of hemoptysis with respiratory compromise secondary to diffuse alveolar hemorrhage (DAH) with an atypical cause.

Case Presentation
A 29-year-old man with history of hypertension presented to a referring facility with subjective fever, cough, and hemoptysis. One month earlier, he had been hospitalized for similar symptoms and treated for pneumonia with complete recovery. He then had recrudescence of hemoptysis and fever 72 hours prior to presentation. He reported tobacco use but denied alcohol or other illicit drug use. He was incarcerated for several months 4 years ago, but denied known exposure to tuberculosis.

On admission, he was hypoxic, requiring 8L of oxygen by nasal cannula to maintain normal saturations. Initial labs were notable only for a white blood cell count (WBC) of 14,600 cells/mL. Chest CT showed extensive ground-glass opacities consistent with diffuse alveolar hemorrhage (DAH). He was treated with intravenous steroids, levofloxacin, and piperacillin-tazobactam, and transferred to the ICU at a tertiary care hospital.

On arrival, the patient was tachypneic but no longer requiring oxygen. His breath sounds were coarse bilaterally with no other abnormalities. A urine drug screen was negative. All infectious studies were normal including HIV antibody/antigen testing, blood cultures, respiratory viral panel, and AFB smears. Autoimmune tests, including ANA, ANCA serologies, anti-phospholipid and anti-glomerular basement membrane antibodies, and complement levels, were also unremarkable. He underwent bronchoscopy that demonstrated diffusely bloody BAL fluid but no source of hemorrhage. BAL cytology contained pigment laden macrophages consistent with injury from inhalation. Upon further questioning, the patient endorsed using synthetic marijuana two weeks earlier, as well as prior to his previous hospitalization for pneumonia. The patient experienced complete resolution of his symptoms and abnormal radiographic findings within 3 days with supportive care alone. The resolution of his imaging findings was so remarkable that the radiologist called to confirm that this was the same patient.

Discussion
DAH has a broad differential diagnosis including systemic vasculitis, infection, hypersensitivity pneumonitis, and inhalational injury (Park MS). The rapid resolution and negative evaluation indicates that this patient’s condition was most likely secondary to “spice,” or synthetic marijuana, which is not always detected on routine urine drug screens. Although rare, this has been reported in a previous case describing a similar presentation and course (Alhadi et al). Recognition of this cause of DAH may become increasingly important as use of synthetic marijuana becomes more widespread, and as many patients view it as a “safer” drug providing a “legal high” (Seely KA et al). This case underscores the importance of taking a thorough social and exposure history in patients presenting with DAH.

References:
Acute Disseminated Encephalomyelitis following Adenovirus Infection in an Adolescent Male
Rami Eltaraboulsi, MD and Eric Stern, MD
Georgetown University Hospital

Case Presentation: A 17-year old male previously healthy presented to our hospital with worsening headache, double vision, and decreased oral intake for one week. On admission, his exam was significant for dysmetria, but otherwise normal neurologic exam. A CT head and brain MRI on admission were normal. A few days into hospitalization, the patient became more somnolent and eventually unresponsive. A lumbar puncture was remarkable for mild lymphocytic pleocytosis. His infectious work up was negative except for a positive adenovirus culture and PCR from the oropharynx. A repeat brain MRI performed ten days from the first, showed subcortical white matter changes throughout. The patient was started on steroids, IVIG, and plasmapheresis. He showed marked improvement within a couple days of treatment. His only neurologic sequelae was arm weakness.

Discussion: Acute Disseminated Encephalomyelitis (ADEM) is an immune-mediated disease that usually occurs after an infection or vaccination. It is more common in pediatrics but occurs in adults as well. The illness usually starts with nonspecific signs like nausea, vomiting, headache then patients can develop neurologic deficits like motor weakness, sensory loss, ataxia, and extrapyramidal symptoms. Their mental status can rapidly deteriorate causing them to become somnolent or comatose. Prompt recognition is crucial since there is a substantial mortality rate.

There is no confirmatory diagnostic test for ADEM. It is important to distinguish infectious encephalitis from ADEM, since ADEM is presumably related to the immunologic response to infection rather than to the pathogen itself. Numerous pathogens have been linked to ADEM including viruses such as CMV, EBV, HIV, influenza, measles, rubella, and bacteria such as Bartonella henselae, Chlamydia, Mycoplasma pneumoniae, beta hemolytic Streptococcus, and the spirochetal infections due to Borrelia burgdorferi and Leptospirae species. Neuroimaging changes is integral to diagnosis as patients will have demyelinating changes in the subcortical or deep white matter only evident on brain MRI. Multiple Sclerosis can look similar to ADEM and should always be considered in the differential, especially if further episodes occur. Immune suppression is the treatment with high-dosed steroids being first line. IVIG and plasmapheresis may be used as alternative agents.

Conclusion: Acute disseminated encephalomyelitis (ADEM) is a rare CNS demyelinating process that can be a diagnostic challenge for the clinician. There are no specific tests that lead to diagnosis and numerous viruses and bacteria have been implicated in ADEM cases. In our case, adenovirus was present on culture and PCR of the oropharynx and testing for this common upper respiratory virus should be considered when evaluating patients for ADEM.

References:

Med-Peds Articles

We love when our fellow Med-Peds physicians are published. Check out the following two articles!

Sarah Palin Is My Muse—And Other Lessons Learned From a Sabbatical
Benjamin R. Doolittle, MD, MDiv, Matthew S. Ellman, MD
http://www.jgme.org/doi/full/10.4300/JGME-D-16-00184.1

Diagnosis and Medication Treatment of Pediatric Hypertension: A Retrospective Cohort Study
https://pediatrics.aappublications.org/content/138/6/e20162195?download=true

Send any Med-Peds pictures, articles, or updates for the Perspective Newsletter or our social media to communications@medpeds.org.
Physical examination was unremarkable. The autoantibodies commonly associated with the disorder were absent from the patient’s serum. However, further laboratory studies provided additional evidence suggesting the patient had DM1 as well as underlying Diabetic Ketoacidosis. He had a blood glucose level of 551 mg/dL and a HbA1c of 10.6%. Renal function was intact but urinalysis revealed a pH of 5.0, 3+ glucose, 2+ ketones, but no microalbuminuria. There was pseudohyponatremia of 124 mEq/L (nl: 136-145 mEq/L) with a serum bicarbonate of 9.1 mEq/L (nl: 22-28 mEq/L) and serum chloride of 92 mEq/L (nl: 95-105 mEq/L) yielding an anion gap of 22.9 mEq/L (nl: 10-14 mEq/L). The diagnosis of DKA was confirmed.

This case demonstrates that the presentation of DM1 is not limited to a bimodal age distribution between 4-6 years and 10-14 years of age as data suggests. Considering the subtle manifestation that DM1 can elicit in a toddler, clinicians need to be hypervigilant of such symptoms. An index of suspicion, no matter how small, should prompt screening, a clinical evaluation, and immediate treatment in the case of disease confirmation. Only prompt control of the condition can prevent the long-term sequelae of vascular and neurological deficit progression. Such comorbid conditions can have significant detrimental effects on quality of life, especially given such early onset of disease.