

The Med-Peds News

Official Newsletter of the National Med-Peds Residents' Association

Mark your Calender! Upcoming Med-Peds Meetings:

APDIM/ACP: April 9th-13th, 2005/14th-16th, 2005

NE Regional Med-Peds Meeting @Brigham & Women's Hospital (Harvard Combined Med-Peds Program), Sat., May 7th, 2005 *see page 10 for more details!*

MPPDA Annual Meeting in conjunction with APPD/PAS in Washington D.C. May 12-14,2005

NMPRA Annual National Meeting/AAP National Conference: Washington D.C. Oct. 8-11, 2005

It's not too early to start thinking about interesting Med-Peds Clinical Cases to present at the NMPRA National Conference!

WWW.MEDPEDS.ORG

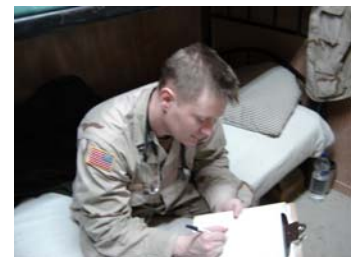
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IRAQ: Saving Lives

As a Med-Peds Resident

By: Shawn Bartel, M.D
Medical College of Wisconsin
Med-Peds PGY3



When I set out for Iraq in early July, I didn't really know what to expect. Like everyone else I was watching the news daily and I thought I was headed for ninety days of misery. On top of the anxiety related to living in a war zone, I was also having serious concerns that my skills after two years of residency would not suffice. I knew a senior resident, chief, or attending would not be a page away during times of uncertainty. But off I went anyway.

Before leaving for Iraq, I spent ten days at Fort Bliss, Texas. During this short period myself and about 200 other soldiers received training in firing weapons, putting on chemical warfare gear, and learning about enemy tactics. This experience made my intern orientation seem like kindergarten. The best part of the ten days was meeting other physicians from all over the country. There were physicians present from multiple specialties, including family practice, pediatric oncology, ER and even pathology. It was comforting to hear these experienced physicians express similar fears and concerns regarding saving lives in combat.

Continued on page 4...

OBESITY: A GROWING EPIDEMIC...

By: Lori A. Porter, D.O.
NMPRA Secretary
Medical College of Wisconsin
Med-Peds PGY-3

The reality is that obesity has become a major

medical concern for both the adult and pediatric populations. More than half of Americans are overweight or obese (2), and the growing rate of childhood obesity is astounding.

The Centers for Disease and Prevention uses data from the National Health & Nutrition Examination Surveys (NHANES) to evaluate the prevalence of obesity in children. This survey has been utilized since 1963 and collects continuous data on children from birth until 19 years of age via a standardized physical exam focusing on height and weight. It is from this data that the BMI-for-age growth charts were first developed to help practitioners identify at risk children.

The 1999-2000 NHANES evaluated approximately 4700 children with a goal to sample minority groups and adolescents. The criteria to qualify as overweight/obese was a BMI > 95% predicted for age. The 1999-2000 survey showed that the prevalence of overweight/obese 2-5 y/o was 10.4% (7.2% in 1998-1994 NHANES data), among 6-11 y/o was 15.3% (11.3% in 1988-1994), and among 12-19 y/o was 15.5% (10.5% in 1988-1994). There was at least a 3% increase in prevalence of obesity across all age groups. Even among infants birth to 23 months of age, 11.4% were overweight when using weight for length $\geq 95^{\text{th}}$ percentile as criteria for overweight/obesity (4). Not only did the 1999-2000 NHANES data confirm increased prevalence of obesity across the board, but it also verified that obesity is most prevalent among minorities, specifically non-Hispanic Blacks and Mexican American adolescents.

It is the vast array of medical complications that are associated with obesity that make this condition a major concern.

Some of the more serious broad complications include:

- abnormal glucose tolerance/insulin resistant diabetes
- obstructive sleep apnea
- hypertension
- metabolic syndrome
- hypercholesteremia
- cardiovascular disease
- gallbladder disease
- orthopedic problems
- hyperandrogenism
- psychological suffering

Of all the medical complications of obesity, non-insulin dependent diabetes is by far the most concerning. Primarily because of the increased morbidity and mortality associated with diabetes, including renal disease, cardiovascular disease, retinopathy, and limb loss. To further support the association between obesity and insulin resistance are studies that show an increase in type 2 diabetes in children that parallels the increased prevalence of obesity.

What is the pathophysiology behind obesity and the development of insulin resistance? One explanation is the lipotoxicity theory which holds that adipose tissue influences the release of cytokines and other proteins, referred to as 'adipokines' (e.g. TNF alpha and IL-6), that directly increase insulin resistance (3). In addition, some of these proteins are pro-inflammatory, which may also be contributing to endothelial dysfunction. This may help explain postmortem findings in children that show increased arterial fatty streak development in overweight children. It appears the extent and severity of atherosclerotic lesions correlates with increased BMI and lipoprotein levels.

The milieu of bad outcomes associated with obesity not only increases medical costs substantially but also decreases life expectancy for young adults (estimates are 5-20 years). On the other hand, for those who acquire obesity later in life and survive to 65 y/o have much larger annual Medicare expenditures than those of normal weight and also have marginally shorter life expectancy. This translates into adult onset obesity costing society a lot more dollars and living just as long. To complicate matters, approximately 50% of overweight adults are uninsured!

Obesity...a growing epidemic cont from pg 2...

Just how much financial burden does this translate into? The 1998 Medical Expenditure Panel Survey (MEPS), the National Health Interview Surveys (NHIS), and the National Health Account Data are the primary sets of data used by the CDC to develop national annual medical spending estimates. According to the above studies, the annual spending attributable to overweight/obesity in adults now rivals that attributable to smoking (9.1%), which is approximately 78.5 billion a year.

Now that we have an understanding of the prevalence of obesity and its financial and life burden, we now have to figure out what we are going to thwart this preventable epidemic. While genetics play a role in obesity, the larger influence appears to be the way our society operates. Some of the following considerations may help explain the increased prevalence of obesity among the American population:

- children/adults are more sedentary than ever
- meals have higher caloric content and serving sizes are twice what they were two decades ago
- fast food market is over-utilized; i.e. 1/3 of American children aged 4-19 y/o eat fast food daily
- increased automated means of transportation
- decrease outside exposure for children secondary to fear of external dangers, i.e. violence
- too much time watching television and using the computer; the rate of obesity is 8.3 x greater in children who watch over 5 hours of television per day vs. those who watch 2 hrs or less/day
- increased vending machines in schools
- decreased perception on the part of parents of child's weight status and their own obesity

When we contemplate all the possible reasons why obesity continues to be an epidemic, it is obvious that it will take a Multidisciplinary team approach (i.e. physicians, parents, schools, dietitian, psychologist, and community resources) to start tackling this epidemic. As Med-Peds physicians, our primary responsibility is to identify patients who are overweight or obese, educate patients/parents, and put patients in contact with community resources that will help them lose weight. Some other basic responsibilities include:

- encourage and support breastfeeding as it is associated with lower rates in obesity in childhood
- promote healthy eating habits with early referrals to nutritionists/dietitians with good follow-up
- ensure parents have a realistic understanding of their BMI and their child's weight status with an understanding of potential endpoints
- encourage an increase in physical activity among children and adults, whether it be organized sports or daily exercise plans with at least 30 minutes of vigorous exercise daily
- knowledge of and implementation of medical therapies that are available to the adult population who have failed conservative measures (e.g. metformin, Xenical, Meridia, topiramate, etc.)
- identify those children and adults who have failed conservative measures and medical therapy who may benefit from endocrinology referral and/or bariatric surgery evaluation

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Iraq: Saving lives as Med/Peds Resident cont from pg 1....

The time at Fort Bliss went fast and before I knew it, I was on the plane headed for Iraq. It seemed almost surreal! The trip took approximately 20 hours with a few stops. The most striking thing when we landed was the heat! The temperature was 100-130 degrees Fahrenheit, and I felt like I was dehydrated incessantly. I could not imagine people surviving in this heat, but as time progressed I grew accustomed. I noted that I had been taking in an extra 5 Liters of free water/day. This likely contributed to my 30 pound weight loss!

I started my medical duties immediately. My responsibilities involved me being the attending physician for the camp clinic at Camp Liberty, just outside of Baghdad. I was fortunate to have two experienced Physician Assistants who taught me so much. In addition, I had the support of twenty paramedics who had already been in the country for six months. They were truly amazing! Most of the paramedics were college students pulled from school. They kept the clinic running in a smooth fashion, and by the end of deployment they were able to give shots, suture, and start IVs. They possessed the skills that the average intern would struggle with. They were also very experienced in the trauma setting, which was paramount to my success during resuscitation efforts.

Our clinic was a small building, which had a trauma bay, 4 clinic rooms, a lab (capable of running basic labs), x-ray room, dental room, and a patient holding room (capable of holding 10 patients for up to 72 hours). A normal day consisted of 3 hours of sick call in the morning and 3 more in the afternoon. The patient populations included US soldiers, soldiers from coalition forces, and Iraqi civilians. The clinic was also available for trauma and emergencies 24 hours/day. This required a healthcare provider to be present at all times, requiring "on call" schedule for a 3-4 day period. There was usually about 50 to 60 patients/day but sometimes we serviced up to 100 patients/day. At times I found myself longing for my Med-Peds clinic at Watertown Plank Road, where the numbers of patients is much more reasonable!

In general, sick call was very much like urgent care, with URIs, muscle strains, and other minor injuries. However, we also attended to more serious injuries and encountered unusual diagnosis, such as leishmaniasis, renal failure, and testicular cancer. While treating coalition forces and Iraqi civilians a broad differential needed to be considered, frequently encountering infectious disease such as pulmonary TB, HIV, and parasitic infections. Trauma care mostly consisted of gun shot wounds, mortar injuries, and injuries from rocket propelled grenades and improvised explosive devices. At first I was terrified of these experiences, but as time went on it became controlled chaos. In general traumas were mostly about stabilization with fluid resuscitation, chest tubes or needle decompressions, pain medications, splinting, and ultimately triaging via medivac to places that offered higher levels of care.



Top Picture: Shawn on far right with other providers in the clinic. Below: Shawn and one of the medics he used to work with in the clinic.

Iraq: A unique Med/Peds Experience cont from pg 4...

My medical duties consumed a large portion of the day; however, there was still ample time which I spent reading, watching movies, and working out. I was stationed in one of the safest places. The camp had a great mess hall by army standards. There was also a gym, shopping center, and even a burger king and pizza hut (see picture on page 14). I even had my own small trailer to myself without the inconvenience of roommates. It reminded me of my call room in the Lower Level, Froedtert Hospital.

Initially, I was only supposed to stay for a 90 day rotation; however, after an attack that sent the Commander Chief Medical Officer and Top Medic out of action, I elected to stay and help. I was Acting Commander Chief Medical Officer which added significant administrative duties and lengthened my stay four more months.

Looking back at the seven month period I spent in Iraq, I realize it represented a huge growth in my professional career. I gained knowledge and skills that I would have never learned in residency. More importantly I gained confidence in myself and the skills and knowledge I already possessed. I definitely saw and experienced things that I will think about for the rest of my life! When I commenced my journey to Iraq I left behind friends, family, and most notably my 19-month-old son, who was just 12 months old when I left. I missed his first few steps, words, and the most painful experience was him not recognizing me when I got home. I will never be able to re-claim that developmental period of his life.

In closing, I would like to say I am proud of the work that our clinic accomplished. I recognize that I was fortunate to work with some of the greatest people on earth, all who sacrificed a year of their lives to help all humanity. I like to think that in some small way I made life a better place for more than just a handful of people.



Congratulations to the following NMPRA Award Winners:

Each winner receives a \$250 educational stipend and \$250 travel grant to the NE Regional Med-Peds Meeting in May 2005 sponsored by: **NMPRA**

Gary Onady Award

Dr. Emery Chang
Tulane University

“For many years, I have been involved at the national level of NMPRA and promoting Med-Peds as a field. I began my involvement in 2002, starting my first term as NMPRA Treasurer...I've had a great time working on Med-Peds issues via the NMPRA and AAP...hope to continue my involvement at local and national levels and that my contributions have made our community stronger.”

This award honors a resident physician making extraordinary, lasting contribution to leadership within NMPRA and/or to the Med-Peds specialty at the *national and/or regional level*. It is named for Gary Onady, MD, PHD for notable, extraordinary, lasting contributions to the Med/Peds profession. In the words of Dr. Onady “The resident recipient will have made a contribution that has moved the Med-Peds specialty to the forefront of medical care policy, curriculum or contributions to the quality of medical care, encompassing the spectrum of training reflected by the Med-Peds specialty.”

The Howard Schubiner Award

Dr. Eric Gustafson
Tulane University

“I have been an active member of my own residency program at Tulane...improving quality of patient care...acting as an advocate and a source of advice in my role of chief resident... have made significant strides in the last few years of improving the efficiency of patient care & the breadth of services offered... (also) frequently counseling students about career choices.”

This award honors a resident physician who has made an extraordinary, lasting contribution to the success of NMPRA and Med/Peds at the *local and/or state level*. It is named for Howard Schubiner, MD, for his notable, extraordinary, lasting contributions to Med/Peds. In the words of Dr. Schubiner “a resident who exemplifies the highest standards for excellence in MedPeds, including exemplary clinical care of patients, compassion and humanism in relationships with patients and colleagues in medicine and hospital coworkers, involvement in community activities, and contributions to the field of Med-Peds.”

EBV and Post-Transplant Lymphoproliferative Disorder

By: Holly Faber, M.D., University of Rochester
NMPRA Member-at-Large

Mrs. W. is a 42 year-old Caucasian woman with a history of bilateral lung transplants in 1998 who presented to the ED with a four-day history of an increase in her chronic cough, fever and chills (to a max of 38.9 degrees Celsius), and decreased oral intake. She had been treated with Amoxicillin as an outpatient for several days and had subsequently developed diarrhea. Her husband had had a fever and sinusitis one week prior; Pneumovax was current, and influenza vaccine had been given the prior winter.

Her past medical history included idiopathic emphysema diagnosed at age 17 (no smoking history or alpha-1 antitrypsin deficiency), bilateral lung transplants followed by two episodes of acute rejection which progressed to stage III chronic rejection, CMV viremia, and recurrent pneumonias over the past year (including viral, Pseudomonas, and Aspergillosis). She was a former secretary on disability for ten years. Her outpatient medicines included prophylaxis with Bactrim, Azithromycin, Itraconazole, and Valgancyclovir, as well as immunosuppression with Tacrolimus, Sirolimus, Mycophenylate mofetil, and Prednisone (10 mg po daily). She was allergic only to Cyclosporine, which was associated with seizures.

On admission, she was afebrile, tachycardic to 122, and had an oxygen saturation of 93% on 3 liters of nasal cannula oxygen. She had labored breathing but clear chest sounds without fremitus or egophony. The rest of the exam was unremarkable. Initial data revealed a decreased WBC count of 3.1 with 63 PMNs and 10 bands; CMV IgG was equivocal, IgM negative, and Tacrolimus and Sirolimus levels were both elevated (27 and 30, respectively). Her chest X-ray revealed a small right lower lobe opacification and some pleural thickening. The initial impression was of a community-acquired pneumonia, likely viral, in the setting of bilateral lung transplants, chronic rejection, and multiple prior infections. She was admitted to a general Medicine floor and treated with Ceftriaxone and Azithromycin, and Prednisone was increased to 40 mg daily.

Over the next two days, Mrs. W's condition worsened, with continuing oxygen desaturations. Ceftriaxone was switched to Cefepime, and Metronidazole added empirically for her diarrhea. She was transferred to the MICU for desaturations to 80% with lethargy and disorientation, and electively intubated for respiratory fatigue. Over the next three weeks, various microbiological results returned positive: influenza A from sputum and bronchioalveolar lavage specimens (thought to be causing ARDS); Pseudomonas from the urine and sputa intermittently; and VRE from the urine. She was treated with a panoply of different antimicrobials at various points, including Caspofungin, Cefepime, Ciprofloxacin, Imipenem, Linezolid, Oseltamivir, and Rimantadine. While her clinical condition continued relatively stable, the fevers persisted on a nearly daily basis. As part of a fever work-up, she had an EBV serum DNA PCR sent, which was significantly elevated at 5000 copies per 100,000 circulating lymphocytes. Associated with this was a steadily rising lymphocyte proportion into the 60s, with PMNs falling to the 20s.

At this point, the major clinical and academic question focused on how to interpret this EBV result. While it might appear to be a work-up for her continued fever (EBV having an incubation period of 30-50 days, which makes mononucleosis a potential pre-hospital infection), in fact this EBV assay was intended to evaluate for post-transplant lymphoproliferative disorder. PTLTD is a clinical spectrum of lymphocyte proliferation disorders following organ transplant, and nearly all are related to EBV infection. There are three main types, of which the first two are reasonably benign, and the third frankly malignant. First, "benign polyclonal lymphoproliferation" consists of a polyclonal expansion of many different B cells with normal cytogenetics and no evidence of IG rearrangements to suggest malignant transformation. It produces an acute illness resembling infectious mononucleosis, and is typically seen two to eight weeks after induction or antirejection therapy. This form accounts for 55% of cases of PTLTD.

(continued next page.....)

EBV and posttransplant proliferative disorder cont from pg 6...

The second type of PTLD, comprising 30% of cases, is called “polyclonal lymphoproliferation with early malignant transformation,” and has a similar clinical presentation to the first. These polyclonal cells, however, do have clonal cytogenetic abnormalities and IG rearrangements indicative of malignancy. In contrast, the third type of PTLD features a *monoclonal* B cell proliferation with frankly malignant cytogenetic features. This condition usually manifests as localized solid tumors affecting various body sites, including the transplanted organ, the GI tract, lungs, skin, liver, or central nervous system. This third form is found in 15% of cases of PTLD.

In order to understand how EBV leads to the development of PTLD, a short review of EBV virology is needed. It is a herpes gamma virus, with double-stranded DNA, an icosahedral capsid, and an envelope. It is considered a transforming virus for its capacity to infect primarily B lymphocytes and give them the potential for malignant transformation. An initial infection with EBV stimulates a cytotoxic T cell response, but approximately one in 100,000 infected B cells are able to survive with latent viral infection, i.e. copies of the EBV viral genome remaining in their cytoplasm. These rare EBV-infected B produce some viral proteins during latency, such as LMP 1 and 2, and EBNA 1 and 2—collectively these substances inhibit apoptosis and stimulate cell growth. Such B cells can grow, immortalized, when cultured from the blood.

Therefore, control of infected B cells depends on an equilibrium with the host’s cytotoxic T cells. As 90-95% of adults worldwide are seropositive for EBV, this cellular push-pull between infected B cells and the T cells which keep them under control is occurring in most of our bodies, all the time. When an organ transplant patient receives immunosuppression, this equilibrium may be disturbed, and the infected B cells can obey their viral commands and proliferate without check. This may result in either a polyclonal or monoclonal proliferation, as described above. In fact, PTLD is among the most serious complications of chronic immunosuppression in organ transplant patients. It is the most common malignancy following transplant, according to statistics from the Cincinnati Transplant Tumor Registry. The incidence varies with the type of organ

transplanted, from 1-2% for liver transplant patients, 1-3% for renal, 2-6% for heart, 2-9% for lung, and up to 11-33% for intestinal or multivisceral transplants.

Many different risk factors affect the development of PTLD. Foremost is the degree of immunosuppression. In one study of more than 50,000 heart and kidney transplants, the incidence of Non-Hodgkin’s lymphoma (which falls under the third, malignant, type of PTLD) was highest in the first year, then fell by 80%. Another study of 41,000 renal transplant patients showed that induction therapy carried the greatest risk of PTLD (RR 1.78), and that specifically Tacrolimus and OKT3 were associated with increased risk..

EBV serostatus is also an important risk factor. One series of 381 adult non-renal transplant patients found a 24-times higher risk for EBV seronegative patients than for seropositive. Another study of lung transplant patients showed that 42% of those who acquired a primary EBV infection after transplant (presumably from the graft itself) went on to develop post-transplant lymphoproliferative disorder. Similarly, although with less obvious explanation, CMV seronegative status prior to transplant also appears to put patients at greater risk for PTLD. In addition, pediatric patients have been found to be more at risk for PTLD. This presumably follows from the fact that children are more likely to be EBV seronegative prior to transplant. In one study of 50 pediatric heart transplant patients, the incidence of PTLD was strikingly correlated with EBV exposure. Thirty-one patients were EBV-seronegative prior to their transplant, and overall, 26% developed PTLD. Of these, 12 of 19 (63%) who converted post-transplant got PTLD, compared to one out of 20 (5%) who were seropositive prior to transplant, and zero out of 12 who remained seronegative both before and after transplant.

The great clinical importance of PTLD makes pressing questions of both prophylaxis and treatment. To prevent PTLD, it is recognized that limiting exposure to intensive immunosuppression is one key factor. Prophylactic treatment with antivirals, such as gancyclovir or acyclovir, may also decrease risk, but more trials are needed.

As for treatment, many strategies are available, including lightening of immunosuppression, antivirals, Rituximab (an antibody against B cells), chemotherapy, surgery, and

EBV and posttransplant proliferative disorder cont from pg 7...

IVIG. Reduction of immunosuppression is the first-line treatment for the two polyclonal forms, and it is most likely to succeed when the PTLD is early-onset post-transplant. Of course, the risk of loss of the transplanted organ presents a constant limiting factor. As for antivirals, there is no firm evidence of efficacy, while Rituximab has had somewhat more documented success. Another possible approach is "adoptive immunotherapy," where leukocytes or even EBV-specific T cells are infused into the patient.

In any case, despite the various therapies available, the prognosis of PTLD remains fairly poor. Though statistics are limited, survival rates appear to range between 25% to 33%, while the mortality with type three (monoclonal malignancy) can be as high as 80%. Returning to the case of Mrs. W., it is still unclear whether PTLD is a factor for her. There are currently no visible signs of soft tissue tumor, but a chest and abdominal CT scan are still pending. Aside from PTLD, it is unclear what else could explain her extremely high EBV titer.

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NMPRA ELECTIONS !

Ranya Sweis, MD, NMPRA President-Elect

It is that time of year again – NMPRA Elections! NMPRA has had a productive year in furthering the cause of Med-Peds and working on projects to help all Med-Peds residents. This was due to the work of the 2004-2005 NMPRA officers and Program Representatives. The four resident officers that comprise the current NMPRA Executive Board are: President- Heather Toth, MD of the Medical College of Wisconsin, President-Elect-Ranya Sweis, MD of the University of Michigan, Secretary- Lori Porter, DO also of the Medical College of Wisconsin, and Treasurer- Emery Chang, MD of Tulane University. We are accepting nominations for the offices of President-Elect, Secretary, and Treasurer for the 2005-2006 academic year.

Nominations can be submitted by e-mail at elections@medpeds.org until Tuesday, May 17th at midnight.

Additional election details and the nomination forms can be found on-line at:

<http://www.med-peds.org/elections2005.htm>



Interested in helping staff a residency fair or giving a talk about Med-Peds to interested medical students???

Contact president@medpeds.org — Upcoming opportunities include:

Tuesday, April 5th @ NY Med for an evening medical student Med-Peds talk

Saturday April 16th, 2-5 pm at the ACP Residency Fair at the Moscone Center in San Francisco

More opportunities to come — let us know if you are able to help!

Med-Peds and Transition Care (Part II)

Niraj Sharma, MD, MPH

President Elect, MPPDA

Co-chair, MPPDA Committee on Transitional Care

Chad Brands, MD

Co-Chair, MPPDA Committee on Transitional Care

The Medicine-Pediatrics Program Directors Association (MPPDA) has taken the lead on addressing the issue of transition care. As is well known, due to improvements in medical care, many children with chronic illnesses are surviving much longer than before. Children with cystic fibrosis, cancer, HIV, and congenital heart defects are now living well into adulthood, creating a growing need for adult medical providers and institutions to offer care for increasing numbers of patients with these conditions

Many of these patients continue to receive medical care from their pediatric subspecialists. Although this may serve the purpose of caring for the particular medical condition from which they suffer, other aspects of adult medical care may not be provided. For example, patients with developmental disabilities have been shown to lack the preventive medical care that they should otherwise receive. One retrospective study of 353 developmentally delayed adults showed that many do not receive preventative services (Lewis et al. 2002). More than 3/4 of participants had received inadequate dental care. Only half of individuals living in community care facilities had received tetanus vaccines, less than half had received the Hepatitis B vaccines, and less than 3/4 had received influenza vaccines. Cervical cancer screenings rates were inadequate, and generally speaking preventative care for individuals living at home or with family members was even poorer. Therefore, finding an appropriate setting to provide adult-centered care is critical.

Physicians who are trained in both internal medicine and pediatrics are well suited to care for these patients. The training in categorical pediatrics gives these physicians the background in pediatric pathophysiology and pharmacotherapeutics while certification in internal medicine allows these physicians to use their expertise to benefit these patients into adulthood. The MPPDA formed the Transition Care Committee in 2003 to provide necessary leadership in transition care.

The committee most recently met during the 2004 MPPDA Annual Meeting in New Orleans. The group, with broad geographic and disease process representation, discussed the spheres of patient care, medical education, and research interfacing with transitional care.

In the practice sphere, the group focused its discussion on how local programs and expert consultants in transition medicine could be used to assist in development of the systems and business of interdisciplinary medical care for new transitional programs. These consultants could lend expertise on: identification of resources, overcoming initial barriers, establishing structures of care, tackling reimbursement and finances, developing business plans. At the APDIM annual meeting in New Orleans, the committee showcased three transitional programs that can serve as models of care around the country: Developmental Disabilities at Case Western Reserve University; Cystic Fibrosis at Yale University; and HIV/AIDS at the University of Miami. We will continue to develop a list of expert consultants who can assist in starting future transition projects. Please contact Dr. Sharma and Dr. Brands at nsharma@miami.med.edu and brands.chad@mayo.edu with your references for the committee's consideration.

In the education sphere, the group determined that there is a real niche and need for curriculum development in this area. Given the increasing numbers of young adults with chronic medical conditions, resident physicians, faculty, and practitioners in pediatrics, medicine and Med-Peds will require medical education on innovative adult care models and practice standards and guidelines. *(continued next page.....)*

Med-Peds and Transition Care Cont. from page 9...

Our plan is to develop a curriculum that categorical internal medicine and Med-Peds residents can utilize during training.

These educational issues have also been addressed through presentations sponsored by MPPDA. As part of the 2004 Annual APDIM Spring Meeting, we gave a presentation entitled "Transitional Care Medicine: Perspectives and Challenges from the MPPDA Committee on Transition Care." The purpose of this workshop was twofold. First, we introduced the concept of transition care and encouraged a view of internal medicine that includes these patient populations. By giving a background on this topic, we hoped that other program directors would realize the importance of educating their residents on issues related to transition care. Second, we highlighted three transition care models where members of the MPPDA have exercised local leadership. Attendees learned how transition care clinics function and how residents learn first hand about issues related to chronic medical care from childhood to adulthood in these settings.

The MPPDA Membership looks forward to continuing to work closely with NMPRA and other interested individuals and societies in developing and promoting educational and clinical programs in transition care. Given the changing demographics of chronic childhood illnesses, these are programs from which our residents and patients will benefit.

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NMPRA Pins On Sale!

Pin A: \$5

and

Pin B: \$4



currently sold out

Place your order by e-mail at
nmpracoordinator@medpeds.org.

Northeast Regional Med-Peds Conference

Brigham & Women's Hospital

Bornstein Amphitheatre

Saturday, May 7th, 2005

8:30 am—5 pm

Topics:

International Health and Refugee Medicine

Adult Congenital Heart Disease

Med-Peds Oncology

Primary Care Topics

Careers in Med-Peds

Residency Options

Opportunities for Networking

The conference is free of charge and open to all including students, faculty, residents, and staff! Additional information to follow.

Please RSVP to Mark Uva at
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Clinician's Corner:

On Empathy, Friendship, & Family: The meaning of Leading a Double-Life

By: Gitanjali Srivastava M.D., Mount Sinai, NYU

As I stared blankly at my laptop screen, I pondered over what should be my next article for the *Clinician's Corner* series. While I was reflecting over the past few weeks, I came to a striking realization: the essence of a clinician not only lies in his intelligence or skill, but also the elegance by which he leads a double life: that of a heroic professional and that of an ordinary bystander among the crowds. As a result, this special article, just as valuable as the others in the *Clinician's Corner* series, is a reminder that doctors, as hero-like as they are, can be human too.

Dec 22, 2004, LaGuardia Airport, NYC. Post-call, tired, hungry, having stayed up all night making certain all admissions were tucked away so there would be minimal work in the morning, I darted outside the hospital and headed straight for the airport. *Would I make it on time? Mom's waiting for me! I'm not packed!* It had been ages since I had last spent the holidays with my parents. I knew they would be waiting, just as excited to see me. This Christmas would be special, the first time in several months that the entire family would be together. I had only two days off, but I was thrilled to make the most of it.

Law #1 Entropy. Nature aims for chaos and disorder. When I arrived at the airport, I hadn't braced myself for the masses of people crowding around ticket counters, frantically dragging their luggage, rushing to catch their flights. *Of course! It's Christmas time and the airport is going to be packed, and the fact that I was admitting patients, going to codes, and counseling a dying patient did not excuse me from the events occurring outside the hospital.* As I checked in my luggage, I noticed my seating assignment was not printed. *That's funny. I distinctly remember having a seating assignment.*

By the time boarding had begun, the airline still had not assigned me a seat, even though I had a confirmed ticket and a confirmed seat. When I heard the final boarding call for my flight, I started to panic. "What do you mean you won't allow me to get on the plane? My luggage is already checked in!" I screamed angrily. "Madam, the plane is overbooked, and no one wants to get off, so we have to decline you seating." *That's ridiculous, that's insane,* I thought. I immediately called my parents. My mother, who's a very sweet, soft-spoken lady, tried to comfort me on the phone and suggested a few options, like flying home the next morning, but the ticket agent quickly dismissed them. "You don't understand! I haven't slept for 40 hours now. I haven't been home for months because I've been working!" I yelled. At this point, I was completely frustrated. I only had two days for break, and I was looking forward to spending that time with my family, and now the airline was telling me that I would have to stay in New York. I was jealous of everyone on that flight. *They all had weeks off, but I only had two days... It's not fair all of my friends are with family during holidays!*

Having run out of options, I felt as if everything was outside my reign, my control. *Control, funny word.* Everyday as a doctor, I plan ahead in a meticulous, organized manner, follow careful details, and maintain control even in the face of death. But here I was, feeling completely powerless. I couldn't help but burst out in tears as I spoke to my mother who kept saying, "We will miss you. We love you.....maybe another time."

Law #2 Sometimes, the best people to love in life are the ones who bring compassion and friendship to another level, the ones who think in ways others do not. I did not have enough cash to even go back to Manhattan from LaGuardia Airport. Needless to say, I got a cab, stopped by the ATM near my apartment building, and quietly paid the taxi driver who was angry with me for doing so. As I explained what had happened to a fellow Med-Peds colleague, she immediately offered something I was lacking, something I will always cherish: her "crazy" family. *(continued next page.....)*

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Law #3 When nothing seems as planned, it's best to follow the natural course of events. Her fiancée stopped by my apartment the next day to pick me up and spend Christmas with her family in the outskirts of New York. Her father and mother, both warm-hearted souls, gave an enormously warm welcome and opened their home to me. Her father kissed me on the cheek and said very simply, "Welcome." This was by far one of the most touching, heart-melting experiences I've had. Thank you, Ofee.

Law #4 There's always a lesson to be learned. So, out of all this chaos, have I learned something new? Absolutely. Although we are taught to excel, to teach, to learn, to help patients throughout our lifetimes, we are not taught how to take care of ourselves in the face of adversity. Yes, our life experiences add another dimension to how we relate to our patients. Our life experiences, both positive and negative, fuel empathy, compassion, and friendship. Therefore, personal growth, whether in the form of time spent with family, friends, significant others, reading, leisure activity among others, is as equally important as professional growth, and without one, the other cannot develop. We cannot concentrate on one, and neglect the other. After all, leading a double-life is a balancing act we should all come to appreciate.

NMPRA Announces New At-Large Board Members

**By: Ranya Sweis, M.D.,
NMPRA President-Elect**

The NMPRA Executive Committee is proud to announce the new At-Large Board Members that joined the Board in January of 2005. These residents have volunteered their time and effort to join the Executive Board in advancing the NMPRA and Med-Peds goals

Holly Faber, MD
University of Rochester

Dr. Faber is originally from Santa Cruz, California. She graduated from Wesleyan University in 1997

with a degree in Medieval History. Prior to medical school at Mt. Sinai School of Medicine, she spent a year in Santiago, Chile teaching English with New World Teachers. During Medical School, she also spent time in Ecuador, Guatemala, and Peru. She matched at the University of Rochester in Med-Peds and continues to use lessons learned in Latin American with her primarily Puerto Rican immigrant patient population. When not at the hospital, she enjoys salsa dancing and travel.

Payel Gupta, MD
Rush University Medical Center

Dr. Gupta was originally born in Kenya and raised in East Lansing, MI. She attended the University of Michigan in Ann Arbor and graduated with majors in Religion and Biopsychology. She began her medical career at Michigan State University College of Human Medicine and is currently in her 1st year of her Med-Peds residency. Her career so far has included many opportunities for volunteering and she has traveled to Ecuador, Honduras, India and Malawi. She has been very actively involved in smoking cessation research and education. She hopes to pursue a fellowship in Allergy and Immunology. She enjoys travel, dance and is learning to play golf.

Alaba Robinson, MD
University of Cincinnati

Dr. Robinson graduated from Howard University in Washington, DC with a major in Biology followed by a Masters of Science in Anatomy. She then attended the University of Wisconsin Medical School prior to starting her Med-Peds residency at the University of Cincinnati. During her years of education and training, she has been very involved in advancing the causes of women and minorities. She has also spent a considerable amount of time on medical research.

MONEY MATTERS....



MAXIMIZING YOUR TIME OFF WITH FREE TRAVEL

BY: EMERY H. CHANG, MD, NMPRA TREASURER

Finally, it's well-deserved vacation time! But does paying for Step 3, your licenses, certifications, credit cards and now student loans, bog you down? Here are some tips to help maximize your time off and get the vacation that you want.

PAID: Many of my friends say, "I don't fly enough to be a 'frequent flier.'" Remember the miles are already paid for as part of your airfare, so it's up to you to sign up and claim them. Plus, there are many ways to get more miles.

Earn miles at home: I earned over 20,000 miles with Delta SkyMiles before I ever got on a Delta flight. You can get miles with cell phone plans, airline credit cards (many fee-free in the first year and large bonuses for your first charge), shopping online at places like target.com, hotel stays, car rentals, taking out a mortgage or car loan, stock trading, opening NetBank accounts and buying groceries. Again, check out the airline webpages for details and links to online shopping.

Credit Cards: There are many cards that offer free travel rewards. Each airline and hotel have cards that earn miles/points in their programs. These can be easy ways to earn free trips or stays, especially if you charge most of your purchases and pay off your balance every month. *Beware* of possible annual fees or high interest rates. Other cards have their own internal program such as Visa Signature Rewards or AMEX Membership Rewards. They offer free trips, shopping, and many other goodies. Make sure to look at all the details of whatever program you chose. To get free vacations it might take you a few years to charge enough, so be prepared to take the time to reach your goal.

Buy cheap, on the same airline: For me, a low fare is my goal. But, when you have choice between airlines, I try to group my flights on the same airline or their alliance partners. For example, I often fly Northwest Airlines and use their WorldPerks program. However, I can also fly Continental, Delta, KLM and many other partner airlines to earn Northwest miles. Another domestic partnership includes US Airways and United. Plus, there are three worldwide alliances which one can earn and redeem miles going all over the world. A quick look at the airlines' website will give you all the details.

Look online! There are often many offers that you can take advantage of listed on-line. Look and register on-line before you fly for specific route bonuses (e.g. double miles between Detroit and the D.C. area on Northwest). Most airlines have bonuses for making flight reservations and checking-in on-line. Sign up for their newsletters, which often have good offers and cheap last minute deals.

Elite? So, most airlines reward their most frequent fliers with elite memberships. Most require that you fly at least 25,000 flight miles in a calendar year. Northwest gives free domestic first-class upgrades, 50-125% bonus miles for each flight, and many other VIP benefits. If you fly an international flight or two, 25,000 miles isn't too hard to do. This can pay off if you try to stick to one airline and their partners.

Points? Most hotel chains have frequent guest programs, similar to airline programs. You can redeem for free nights or trade into airline miles or other goodies. I use Starwood's (hotels include W, Westin, Sheraton) American Express who's points can be redeemed for hotel stays or transferred to many different airline programs.

Money Matters Cont from pg 13....

Finally, *keep track of your numbers*. I have all my cards in one spot and also have a memo in my Palm so that I always have them. Keep track of expiration dates, most miles will not expire as long as you have some activity in your account in the past 3 years. Missing miles, contact the airline and keep your boarding passes. This may all seem to be lots of work, but it really isn't. It just takes a little time to get use to doing it. Enjoy your time off, I'm heading to the US Virgin Islands on a free ticket on US Airways and staying for free at the Marriott Frenchman's Reef Resort with my boyfriend...Happy Trails!

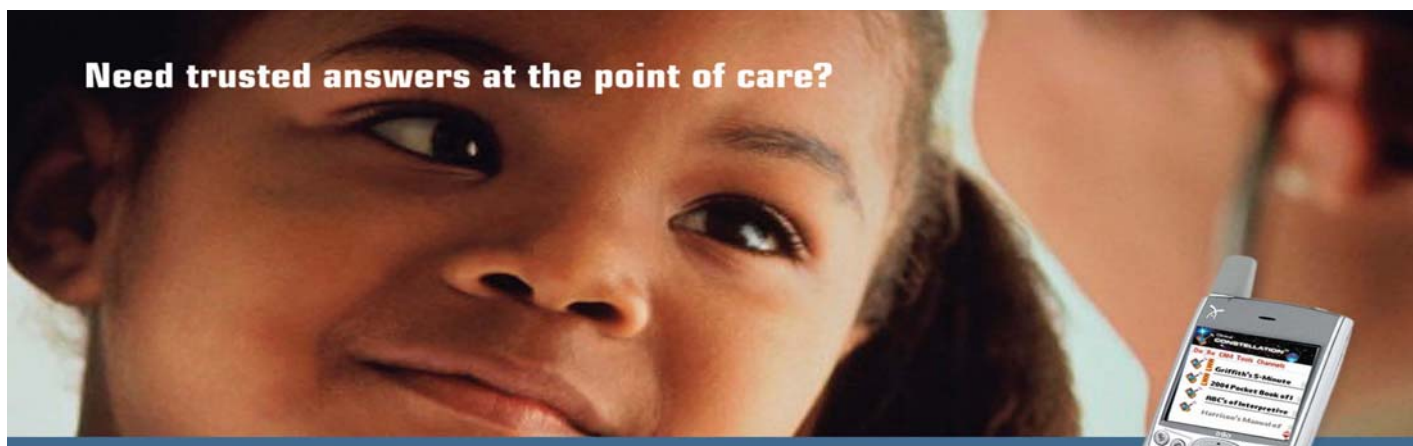


*pictures from article on page 1:
Iraq: Saving Lives as a Med-Peds Resident*



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(The views expressed in this newsletter are those of the authors and not necessarily those of NMPRA)

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The above programs have renewed their memberships for 2004-2005 (as of 3/1/05).

Has your program renewed?

To view the latest active program list, go to www.medpeds.org/Membership/ResidencyDir.asp

To renew your program's membership, go to www.medpeds.org/Membership/Membership_Renew.htm

It's not too early to start thinking of this coming year's membership - our new interns will be here soon!