From the Desk of the President

Kenneth E. Remy, M.D., NMPRA President

Dear Med-Peds Colleagues,

Recruiting is done for the year and the Match is complete! I congratulate everyone on another successful year and welcome the new Med-Peds interns. Currently, NMPRA is embarking on a number of exciting projects dedicated to increasing awareness of Med-Peds around the nation and the ventures, including research and community advocacy, among current residents.

Over the past year, NMPRA has been working at updating and revising our current website (www.medpeds.org). This has been a long and arduous task with many obstacles. Our website has been the busiest Med-Peds related website for many years. By the end of the month we hope to not only have a site where we can successfully disseminate information but also a site that serves useful for students, residents, and attendings interested in many different aspects of career development.

Increasing awareness of our fabulous specialty continues to be a central focus for NMPRA. We are targeting areas where Med-Peds is not prevalent and in the upcoming year, members of NMPRA will be traveling to Atlanta and New York City to promote our field to various medical students. We welcome any suggestions for areas within the country that would benefit from a Med-Peds interest meeting.

NMPRA is also pleased to announce that the Northeast regional meeting will be held on April 28, 2007 in Albany, NY. This is sure to be outstanding following both superb MidWest and National meetings. Future NMPRA meetings include the ACP meeting in San Diego on April 19-21, the Midwest regional meeting in September, date and location still to be announced, and our National meeting at the AAP conference at the end of October in San Francisco. Continued information regarding all these events will be upcoming Perspective issues.

Finally, NMPRA will be unveiling our first ever Advocacy Grants this year at the Program Director’s Meeting in Toronto. We plan to start accepting applications for the upcoming year shortly thereafter. We encourage residents to consider advocacy projects that they would like to embark on or may have already initiated and consider our grant program. Likewise, as the year comes to a close we will be holding NMPRA elections and a call for nominations for both our regional and national awards. More details will follow on these endeavors.

And we finally come back to you; the vital residents and attendings that make our field so special. Please do not hesitate to email me (Kenneth.remy@uhhospitals.org) if you have any questions, concerns, or new ideas to continue advancing this fabulous field we have dedicated ourselves to. Also, if would like to become more involved in NMPRA, our national elections will be approaching soon. Likewise, we will be calling for nominations for both our regional and national awards.

I hope to see you at one of the upcoming events soon.

Ken Remy
Sports Medicine: A Perfect Fit for the Med-Peds Physician

By Corey Dean, M.D., University of Michigan

Dr. Corey Dean graduated from Michigan State Medical School, and then completed residency at the Baystate Med-Peds program in Massachusetts. After residency, he completed a Sports Medicine fellowship at Michigan State. He currently divides his time between inpatient and outpatient care, and teaches our residents in his Sports Medicine Clinic at Eastern Michigan University. He is also the team physician for Lincoln High School, and enjoys teaching on-the-field medical care.

Throughout my life I have always been very interested in sports. It was a release from the boredom of growing up in a place where my nearest neighbor was a half-mile away. I could pick up a basketball and shoot hoops all day long, making the hot, lazy days of summer go by in rural Michigan. Playing collegiate basketball continued to spurn my interest in the connections between sports and medicine. So, as an Internal Medicine-Pediatrics resident, I asked myself, how could I combine my 4 years of primary care training with my lifelong passion for sports? That was when I found out about primary care sports medicine fellowships.

They are a perfect fit for Internal Medicine-Pediatrics residents. One might ask, why would I want to go through another period of training when I have already “sub specialized” for 4 years in Med-Peds? Unlike most fellowships in Pediatrics or Internal Medicine, which are another 3+ years of training, sports medicine fellowships are 1 year in duration (a few are 18 months, but these are being phased out). In addition, as Internal Medicine-Pediatric physicians, we are a perfect match for the adolescent athlete, understanding the fine balance of transitioning from a child to a young adult. Our training is an enviable match for caring for the adolescent athlete in action. So why don’t more Med-Peds residents go into primary care sports medicine?

One barrier to getting accepted into a sports medicine fellowship is that Family practice residency programs have traditionally run them. I personally ran into a few glitches on the interview trail due to my background in Internal Medicine-Pediatrics. However, do not let this deter you if you truly are interested in this primary care specialty. Currently there are several Family practice driven fellowships that have open arms to a variety of primary care backgrounds (including where I trained personally). There are also 5 Pediatric and 1 Internal Medicine driven primary care sports medicine fellowships that understand our natural fit in adolescent sports medicine (see the NRMP website at http://www.nrmp.org/fellow/match_name/sports_med/prev.html for more information). Furthermore, as more and more Med-Peds trained physicians enter the sports medicine field, these barriers are beginning to fall.

So how can one improve their application in being accepted into a sports medicine fellowship? First, I feel a “hands on experience” is paramount. My experience as a resident at the University of Massachusetts in Amherst was critical in my acceptance into my fellowship. I was able to volunteer as the team physician for the Umass soccer teams getting valuable sideline experience. Secondly, while at Umass, I got connected with a mentor in Dr. Pierre Rouzier, their team physician. This helped to form a network of sports medicine trained primary care physicians that I could field questions to and interact with as a resident. Likewise, choosing a research project associated with sports medicine while a resident also helped to bolster my application. Finally, becoming active in your local sports medicine chapter through the ACSM (American College of Sports Medicine) and/or AMSSM (American Medical Society for Sports Medicine) is a great way to network and be noticed in the field.

So once you are trained in primary care sports medicine, what can you do with this specialty? Well, there are many paths you can take. I feel the best path for each individual that entertains sports medicine as a specialty is to look at the lifestyle that they want to live. Sports can be very attractive as they are exciting with traveling all over the country, tending to your high profile athletes. To some, this option of working for a large University or Professional based sports team is enviable. This path usually requires board certification through a certificate of added qualifications in sports medicine (CAQSM). This is now recognized by Internal Medicine and Pediatrics as a separate board certified specialty in medicine. Although not a requirement, I would recommend obtaining the CAQSM after your fellowship as it once again gives you more options.

For others, like myself, the lifestyle of traveling every weekend (and sometimes during the week) is not so conducive to raising a family. So, I chose what I call the “Community based” sports medicine path. I love going to my local high school and covering the Friday night football games on the sideline. Becoming a member of my local community has been great for my personal development and practice as a physician. I also have a sports medicine clinic that I run at a local small college that is a part of my Internal Medicine-Pediatric residency program faculty duties. Furthermore, the best part of becoming a primary care sports medicine physician is, just like Med-Peds, you can make your own path. Isn’t that one of the reasons why you chose Internal Medicine-Pediatrics, because you liked everything in medical school and did not want to just pick one field of practice? So, consider primary care sports medicine as one additional path you can take giving you even more diversity in your career endeavors.
How to Find Time to Exercise:  
A Resident's Quest  
By: Rebecca M. Northway, M.D.

As the snow came down on a February morning, my husband said to me in a sarcastic tone, “Are you going to run in this?” Of course I am. I am a runner. I first picked up the sport in middle school and became serious in high school. I ran collegiate, all be it Division 3, but still, it was a crucial part of my life. I woke up at 5:30 am every other day for two a day practices. I ran on the weekends, I ran in the snow, in the rain, in the 100 degree humidity. And when I got to medical school, I continued to run. I figured, if I could balance my life in college, I should be able to run while in medical school. And that I did, completing three successful marathons with a wonderful friend. So when I got to residency, I figured I should be able to run because after all, I was able to balance my life before.

I was dismally disappointed. I found myself day after day, not having the energy to run. I barely brought myself to climb the stairs at work let alone make it to the gym to ride the elliptical once a week. How was this any different than my previous struggles with balancing life and my desire to run? Sure, I was waking up at 5:30 am every morning, I was on call every 4th night, but my limits were tested before. I had done two a day practices, trained during finals and call in medical school, ran on little sleep after being out with friends. Whatever made this different, I had to figure it out fast, because my running was crucial to my life. Running provides me with many things. It allows me to work towards non-medical oriented goals. I love working on goals other than excelling in medicine. My motivation becomes refreshed and my drive rekindled. I love it that I can achieve a goal I have set, such as running a certain time or distance or training for and completing a race. This new found motivation and self esteem I gain, then trickles into my attitude towards residency. Running also gives me an outlet to vent, to release anger, and to relax. The more I didn’t run, the more I walked around with a short temper. It affected my work, my relationships, my inner being. My parents would call and demand I go for a run, no matter how much I had to do, because afterwards, my focus would improve. And running, regardless of how tired I am, always boosts my energy.

So, I made decision. I had to incorporate running and exercising back into my life. While some of you reading are not runners, I am sure you have all felt the post exercise blues. The ‘blah’ you feel all over when you can’t just exercise in some way, shape, or form. The energy that is just sucked out of you. The way the stairs at the mall just knock the wind right out of you. There are ways to find time to exercise during residency, no matter what time of working fancies you.

The first thing I did was join a gym. There are many types of gyms: big gyms, small gyms, pricey gyms, gyms primarily full of families, students, or just regular folk. I joined the good old YMCA. Other options are the student gyms affiliated with the residency program. Some hospitals also have affiliated gyms. When looking into a gym, check the hours and days it is open because especially with our schedules, this is a major issue. Determine what equipment you want and check it out during the times that you would usually go. For instance, you might want a pool, but if there are only 5 lap lanes open during 2-3pm and the rest of the time it is group swim, this would not be ideal for the overworked resident. Finally, ask what discounts they offer. Many have financial assistance or fees based on income. Also, some give discounts to health professionals or those affiliated with the university or hospital. Finally, some with give larger discounts based on the number of people joining.

Next, I hit the web, searching in my interest of running. I found many running groups, that catered to professionals meeting on the weekends and in the evenings. I made a commitment to attend these meetings on days I wasn’t on call. I have been surprised at the frequency which I can attend. I am also amazed at the support I have received from a number of attendings I work with, whom themselves are committed to similar activities and make it a priority to attend when possible. Meeting at my running group has not only given me an outlet to the intensity of medicine but has also provided me with a new support system and group of friends. I have also been able to network with my fellow runners and learn of other activities in the area.

Finally, I realized that I have to be flexible. Residency, as we all know is hard and chaotic. There are days that I cannot exercise because of call or extended patient care. I have had to learn other activities besides my primary form of running, such as yoga, elliptical, walking, or swimming.

So, I have started to incorporate exercise back into my busy schedule. I no longer walk around like a zombie or ready to lash out at someone because I again have figured out a way to reap the benefits of stress release and relaxation exercise provides. It is important to remember that while residency often seems inflexible, balance is an important key that cannot be lost.
Money Matters: UGH! It’s Tax Time Again...

By Emery Chang, M.D. NMPRA Travel Advisor

So with the New Year, we have to deal with the dreaded finances of the old. As April 17th (not 15th this year) soon approaches and here are a few thoughts I’ve learned from the past few tax years.

Deductions – What is a deduction? They are usually expenses that lower the amount of income that is subject to income taxes. There are two parts to this, first “adjusting” your gross income, which includes moving expenses, IRA contributions, self-employment taxes, and student loan interest. Everyone does this to figure out one’s “adjusted gross income (AGI). The other main deduction is where you choose to take a standard deduction ($5,150 for a single person) or decided to itemize all the other things that could be deducted such as mortgage interest, unreimbursed job expenses, health expenses, and donations.

Moving Expenses – Especially for the interns (and those that will be moving after graduating), if you moved greater than 50 miles, your moving expenses can be deducted from your income. Expenses include costs of packing, shipping, transportation, mileage, connecting & disconnecting utilities, and lodging. These are available regardless of if you “itemize” or not. Details are in IRS Publication 521.

Student Loan Interest – You should receive a 1098 from your loan servicer which states the total paid in 2006. Most residents can deduct up to $2,500 of interest when you are “adjusting” gross income since we make less than $50,000. If you make more, then there is a smaller amount that you may be able to deduct.

Moonlighter? – So often moonlighting pays either as an employee (where they take out taxes and social security) or as an independent contractor (where they don’t). If you are an employee you’ll get a W-2 just like your residency job. However, if you are an independent contractor, then you must pay the 15.3% self-employment tax to make up for the Medicare and social security that hasn’t been paid yet. If you’ll owe more than $1,000 in taxes, make sure you pay them quarterly throughout the year, otherwise you might be short at tax time and be fined a 10% penalty. OUCH!

A bonus of being an independent contractor is that you can deduct usual business expenses from the amount that you were paid including mileage driving to and from the job and required expenses such as fees, medical equipment, insurance and DEA and medical licenses.

Mortgage – One of the best things financially in owning your house or condo is that you can deduct all of the mortgage interest you pay. This also allows you to easily itemize enough deductions to exceed the standard deduction and save you money. You’ll get a 1098 from your mortgage company and do Schedule A for the deduction.

Business Expenses – Unreimbursed costs of being a doctor such as medical exams (USMLE and specialty boards), equipment, insurance, license fees, medical conferences and CME can be deducted if you itemize and use Schedule A. Also, for those that do international rotations or research can also deduct travel costs, daily living allowances (you can do actual costs or use the federal standard per diem) and other related expenses.

On Your Own or With Help? – There are many different ways of filing, through an accountant, with tax software, online or don’t forget Free File available for people with adjusted incomes less than $52,000 available at www.irs.gov. Many of the software programs (including for Free File) are very easy to use, inexpensive and walk you through each step and helps put all the information onto the correct forms. However, if you have some complex tax issues, an experienced accountant may be very beneficial from a time and financial standpoint.

Finally, make sure you keep your receipts and documents. For 2007, keep in mind of what might be helpful for next year in terms of planning and keeping receipts. Good luck in this very confusing and complex process.

The author and NMPRA are NOT tax experts and not responsible for the accuracy of the information provided. Consult your tax professional to see how your individual situation applies.
In the fall of 2002, NMPRA desired to partner with the American Academy of Pediatrics (AAP) Med-Peds Section and the Med-Peds Program Director’s Association (MPPDA) to work on joint projects that would benefit the entire Med-Peds community. One of these initiatives was the idea of the Med-Peds Survey.

One of the challenges for all of us has been the relative lack of facts about Med-Peds. The idea of an annual Med-Peds Survey of graduating Med-Peds residents was to gather facts about Med-Peds residents and to track these facts over time. The initial survey was sent to all graduating Med-Peds residents in the spring of 2003.

The annual survey typically contains a core set of questions about demographics, training experiences, and future plans of graduating Med-Peds Residents. These questions are repeated each year with each graduating class. Each year also has topic questions that change. Topic questions in the past have included such topics as part-time work and outpatient procedures. This year’s topic questions will focus on mental health.

The annual PGY4 AAP Med-Peds Survey is mailed to all graduating Med-Peds residents in the late spring. Results are compiled in the fall and then various abstracts, posters, and publications are prepared based on the data. The first paper from these surveys occurred in Academic Medicine in the spring of 2006, entitled Training Experiences of U.S. Combined Internal Medicine and Pediatrics Residents. A copy of this publication can be found on the NMPRA website at http://www.medpeds.org/PDF/MedPedsResidentsTraining.pdf

Hopefully, as you graduate from your residency program you will continue to add to the data about Med-Peds residents by completing the AAP Med-Peds Survey. If you have any additional questions regarding the AAP Med-Peds Survey feel free to contact me at dkaelber@partners.org.

**New NMPRA 2007-2008 Advocacy and Service Grant**

NMPRA is proud to announce our first annual 2007-2008 NMPRA Advocacy and Service Grant! This grant was developed to encourage and facilitate med-peds residents to pursue projects in their communities that improve the health of adult and pediatric patients. Projects should be directed at providing services to both pediatric and adult patients. Please look for more information and application materials to be announced shortly. For questions, please feel free to contact Arlene Chung, President-Elect at (chunga@ecu.edu). We look forward to receiving your applications!

**Don’t Miss**

The Annual NorthEast Med-Peds Meeting at Albany Medical College, April 28th, 2007
Case Description:

KW is a 17 y/o African-American female with a history of failure to thrive and phenylketonuria (PKU) who weighs 412 pounds on her initial visit. Previously she had been enrolled in multiple weight loss programs with no/minimal effect. Initial evaluation was notable for a history of breathing problems which had been diagnosed as asthma and long-standing hypertension, as well as menstrual irregularity and behavior problems. Her only medication was albuterol, which she used daily. Dietary history was notable for poor food quality and large daily food quantity including many drink calories and snacks. The patient had not participated in any exercise activities for many years. The family history was significant for obesity in her grandparents. The patient lived with her mother and maternal grandfather who were overweight. Her grandfather was suffering from prostate cancer and not motivated to change his diet or lifestyle.

On initial examination, BP 158/88, HR 85 and WT 187kg. Physical exam was significant for acanthosis nigricans on her neck. Laboratory examination included hyperinsulemia, but normal liver function tests, thyroid function tests, basic metabolic panel, and full lipid profile.

Over the first 7 months of her treatment, she had been seen about every 4-6 weeks by a pediatrician and/or nutritionist. A multi-modal approach involving dietary changes, environmental changes, activity changes, motivational interviewing techniques, pharmacological interventions, and co-morbid condition evaluation and treatment had resulted in a 5-15 pound weight loss per visit.

Interventions to date have included nutritionist referral, elimination of calorie drinks (accounting for at least several hundred calories per day), implementation of a 1600 calorie per day calorie goal, installation of a regular activity program through a local senior citizen center (3x per week), movement of the patient and her mother to live in another location without her grandfather, initiation of sibutramine (meridian * appetite suppressant) and hydrochlorothiazide, and psychology referral. All interventions were done with the agreement of the patient and support of her mother and maternal grandmother. Furthermore, many interventions were decided upon by the patient.

Discussion:

This case of a severely overweight teenager demonstrates many characteristics of overweight patients, children and adults, both in terms of their initial presentation and their management.

Many severely overweight children have a history of feeding issues, many times related to being underweight early in life, as seen in this case. Mental illness, abuse, and/or behavior problems are also common in overweight individuals. Another hallmark, especially in overweight children but also in obese adults, is poorly identified and inadequately treated co-morbid conditions. Despite having high blood pressure for years while seeing pediatric providers, this patient was never starting on any antihypertensive medication. Her diagnosis of “asthma”, after additional investigation, appears to be obesity hypoventilation syndrome in combination with poor conditioning. She has since been weaned off her albuterol.

Successful management of weight issues generally requires a multi-pronged approach, which can be coordinated by a primary care provider, coupled with a patient’s desire to improve their health. Efforts should be geared at educating the patient and their family, and involving the patient and their family in the treatment plan. The treatment plan should involve a nutritionist, dietary and activity goals, pharmacological intervention as indicated, specialty consultation as needed (such as psychology), and thorough evaluation and treatment of co-morbid conditions. This should be coupled with frequent follow-up (every 1-2 months), as would typically be done for anyone else with a newly diagnosed chronic disease (e.g. diabetes, asthma, etc.).
Case #2: Recurrent Rhabdomyolysis: What Should a Med-Peds Physician Learn?

By: Rupesh Raina MD

Introduction:

Myoglobinuria is a condition caused by skeletal muscle injury leading to rhabdomyolysis releasing muscle contents into the circulation. It is often associated with acute renal failure. The common conditions associated with rhabdomyolysis and myoglobinuria are ischemic injury to the muscle such as crush injury or compartment syndrome, infections (Coxsackie’s, echo, influenza, measles etc), anesthesia associated succinyl choline, and congenital enzyme deficiencies. Congenital enzyme deficiencies are the most common causes of idiopathic myoglobinuria.

Case Report:

An African American boy 12 years of age presented to the emergency room with a chief complaint of severe muscle soreness and brown urine. Prior to the incident, the boy had been regularly playing football and basketball and had never experienced any significant problems with exercise. He was otherwise healthy with no allergies. According to his parent, the boy had not used dietary supplements. Per family this was his third visit to ED with similar complaints.

The emergency intake records noted temperature 36.6ºC, heart rate 78, respiratory rate 18, and blood pressure 123/72. The boy's height and weight were 170.8 cm and 52.3 kg, respectively. Emergency room urinalysis was positive for myoglobinuria with 2 RBC and negative for ketones. His serum CK was half million U·L-1 (highest reported in literature) and his alanine transaminase (ALT) and aspartate aminotransferase (AST) were 368 U·L-1 and 1520 U·L-1, respectively. His two prior visits showed CK of 150,000 U·L-1 and 40,000 U·L-1. Other blood chemistry and electrolyte profiles were unremarkable.

The boy received intravenous (IV) fluids with 5% glucose, 1/4 normal saline with 30mEq sodium bicarbonate per liter with 2 mEq KCl in 100 mL/h-1 in the emergency room, and 30 mEq sodium bicarbonate and 2 mEq KCl·100 mL-1 during his hospitalization. The boy was discharged after 7 d of hospitalization, and CK was 9101 U·L-1 at this time.

Patient was diagnosed as a case of recurrent heritable childhood myoglobinuria and work-up for congenital enzyme deficiency was sent. A study of the heritable causes of myoglobinuria is important in this case because identification of the biochemical defect may elucidate the pathogenetic mechanism of the myoglobinuria and facilitate the development of rational treatment strategies aimed at circumventing or correcting the metabolic block. The child was diagnosed with palmitoyltransferase II deficiency, the most common inherited disorder of mitochondrial long chain fatty acid oxidation.

Discussion:

Recurrent heritable childhood myoglobinuria is a potentially fatal entity (mortality up to 35%) in which prompt diagnosis and treatment are critical. The most common metabolic cause of recurrent myoglobinuria in both adults and children is carnitine palmitoyltransferase II deficiency. The physician should be alarmed for a metabolic/genetic/enzyme deficiency in patients with recurrent episodes without any antecedent event.

Rhabdomyolysis is a rare clinical entity in a pediatric patient. There are very few documented case reports of myoglobinuria. They usually present with muscle swelling, tenderness and firm consistency of calves and lower back with red urine. It is diagnosed by presence of myoglobin in urine and elevated creatine kinase. Its main complications are hypovolemia and shock due to influx of fluid into damaged muscles, electrolyte disturbances such as hyperkalemia, hyperphosphatemia and hyperuricemia with metastatic calcifications, acute renal failure occurring most often with CK> 16,000 IU/L, urine pH < 5 and arterial pH<7.33, and compartment syndrome.

Management of myoglobinuria involves treatment of any reversible cause of myoglobinuria, aggressive volume resuscitation (as high as 250 – 300 ml/kg in 1st few hours), treatment of hyperkalemia with exchange resins, and treatment of ARF. Aim is to achieve a urine of flow more than 2ml/kg/hr with fluids. Mannitol and bicarbonate infusion can be used to maintain a urine pH of less than 6. Dialysis may be required in 50-70% of patients.
There are many clues from history that can be helpful in detecting a heritable disorder leading to recurrent myoglobinuria and in targeting the metabolic pathway. Development of symptoms after prolonged, mild to moderate, low-intensity activity (such as walking) suggests a defect in fatty acid oxidation (especially if the symptoms occur after 1 hour). Symptoms developing during or after high-intensity isometric exercise (such as pushing a stalled car or lifting weights) or high-intensity, sustained, submaximal exercise (such as sprinting) point towards a defect in glycogen and/or glucose metabolism. These symptoms also tend to occur early in the course of the activity. Defects in glucose, glycogen, or fatty acid metabolism may be observed among patients with symptoms produced by low-intensity, submaximal exercise (e.g., running slowly).

Love Med-Peds So Much, You Can’t Get Enough of It?
Want to Get More Involved?

Consider Becoming Involved in NMPRA
The National Med-Peds Resident’s Association
Positions Available for 2007-2008:
President Elect
Secretary
Treasurer
Members at Large

Watch upcoming Perspectives and emails for details
NMPRA, in conjunction with Albany Medical College and Medical Center, is pleased to announce the annual Northeast Regional Med-Peds Conference on Saturday, April 28, 2007 from 8 am to 5 pm in Albany, New York. This conference will contain lectures divided into two separate tracks, primary care and subspecialty. Lectures in primary care will highlight care of obesity, aesthetics, fever, sports medicine, and contract negotiations. Similarly, subspecialty track lectures will include hematology/oncology, neonatology, and pulmonology, to name a few. The conference will also include a poster competition and a riveting lecture from one clinician’s experience in Iraq. Again, this plans to be a fabulous conference and a great way for residents, fellows, attendings, and students to get together and forge lasting collegial relationships. The agenda is provided below.

**2007 NMPRA Northeast Chapter Meeting**

“Healthy Living: Interventions for the Primary Care Provider”

Saturday, April 28, 2007

8:30 a.m. – 4:30 p.m.

Albany, New York

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Albany Medical College is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The Albany Medical College designates this educational activity for a maximum of 4.5 AMA PRA Category 1 Credits. Physicians should only claim credit commensurate with the extent of their participation in the activity.
It’s a Busy Life, But We All Need a Little Fun!

Med-Peds Residents at the University of Pennsylvannia Health Systems at their Medicine Holiday Party on the right and Welcome BBQ above.

Med-Peds residents go Las Vegas… Watch out!

The University of Michigan Med-Peds residents after a good game of kick-ball!

If you have any photos you would like to see in the Perspective, send them (with brief description to secretary@NMPRA.org
The Official Newsletter of the National Med-Peds Residents’ Association

Not a NMPRA member? To join go to http://www.medpeds.org/Membership/Membership_New.htm

The Med-Peds Perspective

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