



Medical News

MEDICAL UPDATE FOR REFERRING PROVIDERS

Fall 2009

New Specialty Care Center Opens In Shelton

Broad range of pediatric specialty programs now available closer to home.

Connecticut Children's newest Specialty Care Center opened in Shelton on Sept. 14. The state-of-the-art center is in a modern, well-designed building at 4 Corporate Drive, only minutes from Exit 12 off of Route 8. The spacious, 3,300-square-foot suite features eight exam rooms.

"The new Shelton Specialty Care Center makes multi-specialty physician services readily available to children throughout the region," says Annette LeBlanc, satellite manager, who oversaw the new Center's development. "The Center is in a wonderful facility, with ample parking, complete handicap accessibility—even a café patients and families can enjoy."

Specialties available at the Shelton Specialty Care Center are Cardiology, Digestive

Diseases, Endocrinology, Hematology, Nephrology, Orthopaedics, Pulmonary Medicine, Rheumatology, Surgery and Urology. Two outside vendors provide radiology and laboratory services on-site.

"Specialty availability in Shelton will range from once a week to once a month at first, and we will add capacity as growth in volume demands," says Dean Rapoza, executive director of Connecticut Children's Faculty Practice Plan.

Smaller centers in Trumbull and Middlebury were closed and their services consolidated



in Shelton.

The Shelton Specialty Care Center is modeled on Connecticut Children's other Specialty Care Centers in Hartford, Glastonbury and Farmington. For a complete list of locations and the services at each, see page 8. ■

Preventing Sports Injuries

This innovative program keeps young athletes fit, strong and in the game.

You might call it a full-court press. Connecticut Children's Injury Prevention Center and Elite Sports Medicine have teamed up to help athletes boost their performance while avoiding injuries that could sideline them for good. To accomplish this, they've launched an innovative initiative called the Sports Injury Prevention Program (SIPP).

Six million young athletes are injured every year in the United States, and sports-related injuries account for 775,000 Emergency Department visits annually by children ages 5 to 18. The idea of the SIPP program is to work with school athletic teams and individual athletes early on to educate, strengthen

and condition players appropriately so as to reduce their risk of injury.

"Our premier program is the Knee Injury Prevention Program," says SIPP Program Manager Laura Miele, PhD. "We work with athletes to strengthen lower-extremity and abdominal muscles, especially the hip adductors and abductors. We teach them how to move with a better functional technique—how to jump and land properly so they are less likely to sustain a knee injury."

SIPP also offers a Hip and Core Conditioning Program and a Shoulder and Elbow Conditioning Program.



Continued on page 2

CASE REVIEW More Dangers Of Dope

Aaron Zucker, MD, division chief and pediatric critical care director in Connecticut Children's Pediatric Intensive Care Unit, provided this issue's case.

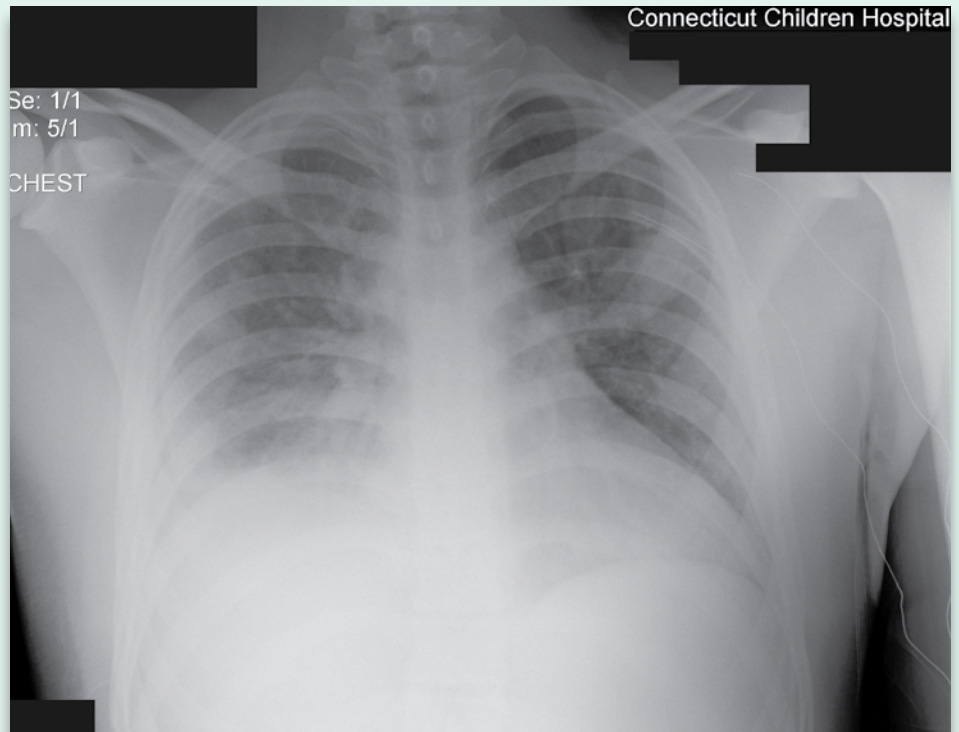
Presentation

A previously healthy 17-year-old boy had a one-week history of malaise, fevers, sore throat, pleuritic chest pain, profound anorexia with weight loss, and night sweats. His pediatrician prescribed prednisone for tonsillitis, but when the patient developed dyspnea, he was referred to the Connecticut Children's Emergency Department. There were no sick contacts at home or relevant medical history, and he admitted to smoking marijuana several times per week. He was afebrile, normotensive and in moderate respiratory distress with respiratory rate of 24/min. Pertinent exam findings included erythematous tonsils with minimal white exudates, normal soft palate and neck exams and normal heart sounds. He had intercostal retractions with normal air entry on the left side and almost no air entry on the right. There were no rales or wheezes. A chest X-ray disclosed a very large, right pleural effusion with underlying infiltrate and a small apical pneumothorax.

Labs were: Normal electrolytes, BUN > 80 mg/dL, creatinine = 3.8 mg/dL, white blood cell count: 26,200 (myelos 1%, metas 5%, bands 51%, polys 35%, lymphs 4%), platelet count = 75,000, hemoglobin = 15.4 g/dL, C-reactive protein = 45 mg/dL (normal 0-0.45).

Diagnosis/Treatment

With a presumptive diagnosis of bacterial pneumonia, along with sepsis and dehydration (and lesser suspicion of malignancy), antibiotic therapy with vancomycin and ceftriaxone was empirically begun. He acutely worsened as we prepared to place a chest tube for diagnostic and therapeutic purposes. Thoracentesis



Chest X-ray shows large, right-sided pleural effusion with underlying parenchymal consolidation, as well as a small apical pneumothorax.

yielded thick, extremely foul-smelling fluid, and the patient improved significantly when a liter was removed. A chest X-ray showed that most of the effusion was gone, allowing better visualization of dense right-lower-lobe consolidation. He had intermittent episodes of rigors and hypotension, which responded to intravenous boluses of normal saline. Within hours of the thoracentesis, the laboratory staff reported that the pleural fluid was loaded with bacteria (thought to be Staphylococci and "an anaerobic bacillus" by Gram stain). Characteristics of this exudate included glucose <2 mg/dL, LDH=63,600 U/L, albumin

= 2.2 g/dL, and 175,000 white blood cells/mm³. No malignant cells were seen.

Overnight, he continued to have periods of shaking chills and fevers. When shortness of breath recurred, he responded well to non-invasive breathing support with bilevel positive airway pressure (BiPAP) therapy. Within hours, his pleural fluid grew "mixed anaerobic flora," and his blood culture grew Gram negative, identified the next day as *Fusobacterium necrophorum*. His antibiotic regimen was changed to ampicillin/sulbactam, and when his chest tube did not suffice for satisfactory total drainage of

Continued on page 5

Preventing Sports Injuries *Continued from page 1*

Dr. Miele ran a speed, agility and sports-injury-prevention program this past summer that drew athletes from all over the area. She and her fellow trainers work with high schools, soccer clubs, AAU basketball programs and other organizations, but also offer individualized programs for athletes.

"Everything we do is clinically based, and our exercises are based on other successful

national programs," Dr. Miele says. "Then I use my own knowledge and experience to add appropriate exercises."

A former Division I athlete, Dr. Miele holds a doctorate in sports psychology from Capella University. She played basketball at Arizona State University, played tight end on one of the first women's professional football teams and was a Golden Gloves boxer in

New York City. She's been coaching since 1989 and training athletes since 1994.

"I have a lot of energy, and I love working with kids," Dr. Miele says. "The bottom line of this program, though, is that we want to keep athletes healthy."

To refer a patient to the Sports Injury Prevention Program, or to learn more, contact **Laura Miele** at **860.284.0288** or Immiele@connecticutchildrens.org. ■

Welcome Aboard!

A warm welcome to the newest members of our medical staff.



Cem S. Demirci, MD, FAAP
Endocrinology

- Fellowship in pediatric endocrinology and diabetes, Children's Hospital of Pittsburgh, University of Pittsburgh Medical Center

- Attending physician, Department of Pediatrics, Michigan State University, Hurley Medical Center
- Residency in pediatrics, Michigan State University, Hurley Medical Center
- Research fellow, Department of Surgery, University of Texas Health Science Center at San Antonio
- General practitioner, Department of Ambulatory Medicine, Haydarpasa Numune Hospital, Istanbul
- MD, University of Istanbul Medical School at Cerrahpasa



Umit Emre, MD, FAAP
Pulmonology

- Attending pediatrician, pediatric pulmonology, Beth Israel Medical Center
- Clinical and research fellow in pediatric

pulmonology, State University of New York Downstate Medical Center

- Internship/residency in pediatrics, State University of New York Downstate Medical Center
- Internship/residency in pediatrics, Istanbul School of Medicine, University of Istanbul
- MD, Istanbul School of Medicine, University of Istanbul



Nina McFarlane-Johansson, MD
Emergency Medicine Fellow

- Attending physician, pediatric emergency medicine, Staten Island University Hospital
- Residency in pediatrics,

State University of New York Downstate Medical Center

- MD, Ross University School of Medicine
- BS, biology, Harvard University



Sarah Schlegel, MD
Developmental and Behavioral Pediatrics

- Fellowship in developmental-behavioral pediatrics, Yale University
- Residency in pediatrics,

Stony Brook University Hospital

- MD, University of Connecticut School of Medicine
- BA, neuroscience and behavior, Wesleyan University



Kristin Welch, MD
Emergency Medicine

- Fellowship in pediatric emergency medicine, University of Connecticut/Connecticut Children's Medical Center
- Residency in pediatrics,

University of Washington/Seattle Children's Hospital

- MD, Washington University School of Medicine
- BS, psychology/neuroscience, Duke University

Help For The Grieving

Connecticut Children's Bereavement Committee offers comfort and support to families who've lost a child.

In the event of a patient's death, community providers can help the child's family obtain vital support by contacting Connecticut Children's Bereavement Committee. The committee's mission is to reach out to families to help them cope with their loss, work through their grief and, ultimately, find comfort in celebrating their child's life.

The Bereavement Committee is made up of physicians, nurses and members of the hospital's Child and Family Support staff. It is lead by pediatric intensivist Leonard Comeau, MD, and social worker Priscilla Pandozzi, LCSW.

The group holds two memorial events each year for families who have suffered the death of a child. One is held off-site every June. It often includes poetry, nondenominational prayer, music and an opportunity for parents to talk about their children. Last year's event

featured the creation of a wind catcher, which now hangs in the hospital's meditation room. This year, attendees created bouquets, with each flower representing a child.

"We've had some families come to this every year for 10 years," says Dr. Comeau. "There aren't that many other opportunities for families to get together with other families who have experienced this loss."

The other annual event, held in December, is a holiday remembrance. Families are invited to gather for dinner at the hospital and take part in a craft activity. Physicians and staff members are encouraged to attend both events.

The committee offers a Bereaved Parent Support Group that meets on the third Thursday of every month from 6:30 to 8 pm at Emanuel Lutheran Church on Capitol

Avenue in Hartford. Ms. Pandozzi co-facilitates the group with a bereaved parent.

"Our group is unique because it is the only support group exclusively for parents who have lost a child under age 18," Ms. Pandozzi says.

Quarterly sibling support groups are also available.

Members of the committee go out to visit families whose children died at Connecticut Children's, and they serve as resources to schools and other community groups.

"Having a child die is the biggest stressor a family is ever going to experience," says Ms. Pandozzi. "We know they need support, so we reach out in any way we can to try to provide it"

To refer a family or learn more about bereavement support, contact **Ms. Pandozzi at 860.545.8965** or ppandoz@connecticutchildrens.org. ■

A Healthy Dose Of Info Online

Connecticut Children's new Web site features a library of health information for all ages.

Now kids, teens and parents can get trustworthy information on a host of health topics, just by visiting the KidsHealth section of Connecticut Children's new Web site (www.connecticutchildrens.org).

Users enter KidsHealth by clicking on one of three age-based boxes at the bottom left of the site's home page. Topics range from nutrition and wellness to specific conditions to dealing with emotions and just learning how the body works. Articles are available in both English and Spanish. The information is presented in age-appropriate styles—lots of videos and bright colors in the children's section; a cool, conversational tone for teens; and a lively, straightforward approach for parents.

SUPERIOR PRODUCT

Connecticut Children's licenses the KidsHealth product from a vendor that draws information from a wide range of medical resources, including physicians, nurses and professional health organizations. KidsHealth is a program of the Nemours



Foundation's Center for Children's Health Media

Clinical Education Specialist Sally Strange, PhD(c), and pediatric intensivist Heather Schlott, MD, worked with a multidisciplinary work group and the hospital's Family Advisory Board to select the best product for the new Web site.

"We looked at what was available from various vendors, and this was a superior product," says Ms. Strange. "It's pediatric-specific, so users don't have to sort through a lot of information aimed at adult health, and it's used by many other pediatric hospitals."

"Families today search the Internet for health information," says Dr. Schlott. "We wanted to help them find reliable sources because, unfortunately, there are many unreliable sources out there."

MULTIPLE USES

In addition to providing health information to individual users, KidsHealth is a good resource for pediatricians, school nurses and teachers.

"Physicians can print a handout on a topic and use it to supplement education they're providing for patients and families in the office," Dr. Schlott notes.

Teachers can use materials in lesson plans, and school nurses can make them available to health classes or individual students.

Dr. Schlott and Ms. Strange hope that these professionals will also spread the word about the site, so that young people and their families can take advantage of it. They also welcome feedback, which can be sent using the "Contact Us" button on the home page.

"If there's an information gap that needs to be filled, we want to know about it," Ms. Strange says.

HEALTH INFORMATION LIBRARY

KidsHealth is just one component of an extensive health information library now available on Connecticut Children's Web site. Clicking on "Health Information" gives users access to Krames Online, HouseCalls Online, a medical dictionary and much more. All represent Connecticut Children's commitment to making reliable information readily available to all.

To discuss KidsHealth, contact Heather Schlott at hschlott@connecticutchildrens.org or Sally Strange at sstrang@connecticutchildrens.org. ■

Fax The Facts For Nutrition Consultation

When you decide that a patient needs a nutrition consultation, Connecticut Children's Department of Clinical Nutrition Services is ready to help. The department's registered dietitians are expert nutritionists experienced in pediatric care, and they're committed to responding quickly to referrals. To help ensure a prompt, high-quality consultation,

the department has developed an Outpatient Nutrition Consultation Referral form for your use. Just check off the diagnosis, fill in the patient contact information, add any notes you think helpful and fax it over. The Clinical Nutrition team will take it from there.

"There are hundreds of nutrition conditions that might lead to a referral," says the department's

manager, Claire Dalidowitz, RD. "Knowing exactly what the patient's problem is allows us to prepare appropriately for the visit and assign the best person to the case. It helps us do the best job for that patient"

For a supply of referral forms, call the Clinical Nutrition Services office at **860.610.4286**. Fax completed forms to **860.610.4283**. ■

More Dangers Of Dope

Continued from page 2

the effusion, he underwent a video-assisted thoracoscopy procedure on day number four. He was transferred to the floor two days later. Ultrasound exam of his left internal jugular vein showed a thrombus, clinching the diagnosis of Lemierre's Syndrome. He went home with an indwelling intravenous catheter for a planned six-week antibiotic course. However, although he remained asymptomatic and regained weight, he developed a cavitary lesion in his left upper lobe, so antibiotic therapy was continued even longer until the cavity resolved. He still has residual thick pleura at the left lung base, but he is otherwise doing well.

Discussion

This young man presented with bacterial pneumonia, parapneumonic effusion and an associated blood-borne infection. We encounter this scenario rather frequently, but the putrid nature of the effusion, along with subsequent identification of *Fusobacterium necrophorum*, was unusual. We have dealt with this necrotizing anaerobic bacillus several times in recent years in patients with Lemierre's Syndrome, which was first described in 1936. These patients develop septic thrombophlebitis of the internal jugular vein as bacteria causing pharyngitis (less often otitis or mastoiditis) spread through the deep fascial planes of the neck into the carotid sheath. If pharyngitis is the initial problem, there is usually painful swelling of the soft palate and uvula, as well as the lateral neck parallel to the sternocleidomastoid muscle. Sepsis and distant metastatic infections may occur in the lungs and other organs. Before the antibiotic era, this syndrome was seen more often than it is today, and mortality rates were extremely high.

Our patient had a recent history of pharyngitis, but at presentation this was insignificant, and he had no palatal or neck involvement. So, how else might he have developed invasive, life-threatening *Fusobacterium* infection in his lungs and

bloodstream? Further questioning about his recent activities led to the answer. When pressed for details about his marijuana use, he said that he had smoked using a "bong," a cylindrical water-filled pipe that may be used by many people and is rarely cleaned between uses, making it a perfect medium for bacterial multiplication. He recalled that he recently had ingested some of the water and later vomited. It seems likely, therefore, that he aspirated the *Fusobacterium* directly into his lungs. This is different from the usual mechanism of bacterial spread typically associated with Lemierre's Syndrome. It is fortunate that the Infectious Disease consultant asked for the neck ultrasound study based solely on the identified bacterial species, because the jugular thrombus mandated extended outpatient antibiotic treatment.

One other aspect of his treatment warrants discussion. In the past, a patient with his magnitude of pulmonary insufficiency likely would have been intubated and mechanically ventilated, with all the potential downsides of such interventions, until chest drainage was complete and his lungs had improved considerably. However, we now frequently have great success with non-invasive support with BiPAP, in which a combination of end-expiratory pressure to keep the lungs inflated and a further inspiratory pressure boost to augment inhaled tidal volumes is administered via a tight-fitting mask. This often suffices until the patient begins to improve and can breathe comfortably without pressurized assistance.

When we think of the most dangerous "recreational chemicals," marijuana usually is not very high on the list. In this case, it was not the drug itself, but the surrounding events, that led to a life-threatening pulmonary and blood-borne infection. This case refutes assertions that marijuana is not a dangerous drug and underscores how important it is to educate young people to the very real dangers of marijuana use. ■

Co-Management Workshops Under Way

One of the recommendations that emerged from the ongoing Referring Provider Relations Project was the development of co-management options for selected conditions. This initiative has been moving forward. The first two educational workshops for practitioners interested in co-management were held this fall, and a third is planned for early 2010. Presenters typically are the subspecialist and referring provider who co-authored each protocol. Workshops are free of charge.

A workshop on co-management of hematuria will be held on Jan. 27, 2010, from 5:30 to 8:30 p.m. in room 118 of Hartford Hospital's Jefferson Building. Presenters are Majid Rasoulpour, MD, pediatric nephrologist at Connecticut Children's and professor of pediatrics at the University of Connecticut School of Medicine; and Carol Erickson, APRN, of ProHealth Physicians, office of Gerald Calnen, MD, in Enfield. A buffet dinner will be provided.

On Oct. 8, a workshop on pediatric voiding dysfunction was held. Presenters were John Makari, MD, pediatric urologist at Connecticut Children's and assistant professor of surgery (urology) at the University of Connecticut School of Medicine; and Jennifer Schwab, MD, a partner in Fote & Schwab MDs LLC of Rocky Hill and clinical instructor of pediatrics at the University of Connecticut School of Medicine.

A workshop on fibromyalgia and chronic fatigue syndrome in children was held on Nov. 4. Presenters were Lawrence Zemel, MD, chief of the Division of Rheumatology at Connecticut Children's and professor of pediatrics at the University of Connecticut School of Medicine; and Michael Curi, MD, attending physician at Charlotte Hungerford Hospital and clinical professor of pediatrics at the University of Connecticut School of Medicine.

For information about future workshops, contact Diane Mouradjian at 860.610.4264 or dmouradjian@connecticutchildrens.org. ■

Grand Rounds Online

Earn CME credit from your home or office by accessing selected Grand Rounds presentations online. Just go to connecticutchildrens.org to register and obtain a password.

For more information, contact Diane Mouradjian at dmouradjian@connecticutchildrens.org or 860.610.4264 or fax 860.610.4261. ■

Collaborating In Care

The Northern Connecticut Neonatal Collaborative aims to enhance neonatal care.

Under the leadership of Connecticut Children's, providers at 19 hospitals in eastern, central and northwestern Connecticut have come together to form a unique partnership focused on continuously improving neonatal care.

"Our goal is to work together, exchange information, share resources and try to overcome the typical competition that impedes making progress in newborn care," says Marilyn Sanders, MD, a Connecticut Children's neonatologist who leads the group's steering committee. The steering committee includes representatives from Connecticut Children's, Eastern Connecticut Health Network, the University of Connecticut Health Center and the Hospital of Central Connecticut.

The collaborative grew out of a meeting hospital providers held in late 2008. At that gathering—the first of its kind in the state—providers discussed what would be helpful to them in improving the quality of care given to newborns delivered in the region's hospitals.

"One of the recommendations that came out of the meeting was to create a regional neonatal Web site so we can share information regarding educational programming, policies and guidelines for addressing common newborn clinical conditions," says Dr. Sanders. "In the long term, we also hope to develop a forum for sharing data on newborn outcomes throughout the region and to give feedback to hospitals so they can



benchmark themselves in key areas."

The regional conference also identified implementation of a neonatal simulation program as a key step in learning and maintaining critical newborn resuscitation skills. The Division of Neonatology at Connecticut Children's is collaborating with the Simulation Center at Hartford Hospital in developing the first newborn simulation program in the state. Newborn simulation exercises are already used in residency training, and the group aims to

make such training available to community physicians, midlevel practitioners and nurses at hospitals in the region.

"Simulation will allow neonatal providers to practice emergency stabilization skills," says Dr. Sanders. "They don't need to use these skills very often, but when they do, it's a matter of life and death."

For more information on the Northern Connecticut Neonatal Collaborative, contact Dr. Sanders at 860.545.8972 or msander@connecticutchildrens.org. ■

Add The Pedi Advice Line To Your Practice

If the prospects of being on call during the fall and winter of an impending influenza epidemic strike you as daunting, consider using the after-hours Pediatric Advice Line (PAL) to handle your calls.

More than 300 pediatricians and other providers are currently enrolled with the PAL. Thanks to the PAL's recent partnership with the Rainbow Babies and Children's Hospital Call Center in Cleveland, Ohio, the PAL now has the

capacity to enroll even more practices.

Here's how the PAL works: After hours, your parents/patients continue to call your answering service. Their calls are returned by the pediatric RNs at the Rainbow Call Center who utilize the computerized version of the telephone triage guidelines published by the renowned Dr. Barton Schmitt. Reports of the calls are faxed overnight to your office.

Schmitt's research has proved that 80

percent of after-hours calls can be handled by experienced triage nurses and that just 20 percent of the calls require intervention by the on-call physician or emergency medical services. The bottom line is that, by using the PAL, pediatricians can get more rest overnight or over the course of the weekend on call.

For more information about the PAL or references on its services, contact Dennis Crean at 860.610.4248 or dcrean@connecticutchildrens.org. ■

Old Blood Cells May Double Mortality In Trauma Patients, According To Research By Doctors At Connecticut Children's Medical Center

Severe trauma patients requiring a major transfusion are twice as likely to die if they receive red blood cells stored for a month or longer, according to research published in BioMed Central's open access journal *Critical Care*. The increased rate of death was measured up to six months post transfusion, which is consistent with previous reports in cardiac surgery patients.

Philip Spinella, MD, and Christopher Carroll, MD, MS, both pediatric intensivists from Connecticut Children's Medical Center, and their team studied 202 severe trauma patients treated with five or more units of red blood cells following a critical injury. They found that even one unit of red blood cells stored more than 28 days doubled the incidence of deep vein thrombosis and increased death secondary to multiple organ failure. Though medical experts long had suspected that older red blood cells caused complications, this is one of the first studies to strongly support this dramatic link. This study differs from previous studies since the amount of RBC units transfused to the fresh and old RBC study groups were equal. As a result, this eliminated the major criticism of previous studies that it is the amount of RBCs transfused, not the storage age, that affects outcomes.

More than 29 million units of blood were transfused in the United States in 2004, and this is a routine and reliable part of trauma care treatment around the world. However, red blood cell transfusion continues to be associated with adverse complications. This study provides evidence that allows doctors to reduce these risks by giving fresher red blood cells to severe trauma patients who need these major transfusions for life-saving procedures.

"The preferential use of younger RBCs to critically ill patients has the potential to increase waste due to outdated. Since blood

is often a scarce resource, this is important, and methods need to be developed to minimize waste while providing the most efficacious and safe blood product for a given patient," said Dr. Spinella. "Our hypothesis is that the sicker a patient is, the more important it is to receive fresh blood. Studies need to continue to determine which patients require fresh blood and which don't. While previous evidence indicates that old blood is associated with increased inflammation and immune and vasoregulatory dysfunction, our study provides indirect evidence that old blood may lead to increased clotting, which is an additional mechanism that needs to be further explored."

Dr. Spinella added that these important findings should encourage research into the effects of old blood and coagulation in critically ill patients.

"With the widespread use of red blood cell transfusion for critically injured patients, this study has the potential to cut deaths in hospitals around the world," Dr. Spinella says. ■

*"Twice as likely
to die if they
receive red blood
cells stored for
a month or
longer."*

Please Join Us

All lectures are held at the Pond House Café
1555 Asylum Ave., West Hartford, Conn
Dinner 5:30 pm; lecture 6:30 – 8 pm

Pediatric Evening Lecture Series

Nov. 19, 2009

Beyond Otitis Media (ENT)

Speaker: Scott Schoem, MD, chief, Division of Otolaryngology, Connecticut Children's Medical Center; professor of pediatrics, University of Connecticut School of Medicine.

Feb. 11, 2010

Infectious Disease Update

Speaker: Juan Salazar, MD, chief, Division of Infectious Diseases, Connecticut Children's Medical Center; associate professor of pediatrics, University of Connecticut School of Medicine.

April 27, 2010

Practical Approaches to Anemia and Bleeding During Childhood and Adolescence

Speaker: Nathan Hagstrom, MD, chief, Division of Hematology/Oncology, Connecticut Children's Medical Center; assistant professor of pediatrics, University of Connecticut School of Medicine.

Andrulonis Child Mental Health Evening Lecture Series

Jan. 14, 2010

Psychopharmacology Update

Speaker: Lisa Namerow, MD, Division of Psychiatry, Connecticut Children's Medical Center; attending physician, Child & Adolescent Psychiatry, Institute of Living/Hartford Hospital; director, Child & Adolescent Psychiatry Residency Program, Hartford Hospital; assistant professor of psychiatry, University of Connecticut School of Medicine.

March 11, 2010

Bipolar Disorder: Category or Dimension?

Speaker: Stuart Goldman, MD, assistant professor of psychiatry, Harvard University School of Medicine; co-director, Mood Disorder Program, Children's Hospital of Boston.

For up-to-the-minute information, visit

connecticutchildrens.org/continuingmedicaleducation.asp
or call **860.610.4264** or fax **860.610.4261**. ■



Medical News

MEDICAL UPDATE FOR COMMUNITY PHYSICIANS

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Important Numbers

For all admissions: **877.MDADMIT**. To contact a specialty service for your patient, call the physician liaison at: **888.KIDS.778**

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Connecticut Children's Medical Center
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Hartford, CT 06106

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Connecticut Children's Medical Center at Your Service

Connecticut Children's provides a variety of services at locations statewide and beyond. Here's a summary:

Avon, 120 Simsbury Road

Audiology • Ear, Nose and Throat • Speech-Language

Farmington, 399 Farmington Avenue

Center for Motion Analysis • Endocrinology • Gastroenterology •
Hematology/Oncology • Occupational Therapy • Orthopaedics •
Physical Therapy • Pulmonary Medicine • Radiology •
Speech-Language • Sports Medicine • Surgery • Urology

Glastonbury, 310 Western Boulevard

Audiology • Cardiology • Ear, Nose and Throat • Endocrinology •
Gastroenterology • Hematology/Oncology • Neurology •
Occupational and Physical Therapy • Orthopaedics •
Pulmonary Medicine • Radiology • Speech-Language

Madison, 1347 Boston Post Road

Cardiology

Manchester, 71 Haynes Street

Cardiology

Middletown, 520 Saybrook Road

Cardiology

New Britain, 100 Grand St.

Cardiology • Pulmonary Medicine

New London, 365 Montauk Avenue

Rheumatology

Norwich, 44 Stott Avenue

Genetics

Putnam, 320 Pomfret Street

Cardiology

Shelton, 4 Corporate Drive

Cardiology • Digestive Diseases • Endocrinology • Hematology
Nephrology • Orthopaedics • Pulmonary Medicine • Rheumatology
Surgery • Urology

Southbury, 22 Old Waterbury Road, Suite 201

Cardiology

Stamford, 32 Strawberry Hill Court

Endocrinology • Orthopaedics • Rheumatology

Torrington, 157 Litchfield Street

Cardiology • Endocrinology

Waterbury, 64 Robbins Street

Cardiology

Massachusetts, 516 Carew Street, Springfield

Rheumatology • Neurosurgery



To make an appointment, call the specialty's main number as listed in the "Directory of Medical Programs and Services."