MedicalCurrents

A Children's National Medical Center Quarterly Publication for Physicians

Fall 2012

Children's National Medical Center

One-On-One with Timothy Kane, MD
New Chief of General and Thoracic Surgery

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Alumni *Spotlight*

Brenda Jo Simmons, PhD, passed away at age 61 on Sunday, August 12, 2012. Dr. Simmons served as the Chief of Pharmacy at Children's National. She joined Children's in October 2007 and transformed the Division of Pharmacy into a world-class service. She is remembered for her caring spirit, dedication to the safe and efficient treatment of our patients, and her devotion to her pharmacy and Children's National family.

News *Notes*

Cardiology Services Now Offered at Reston Hospital Center

Children's National now offers cardiology services at Reston Hospital Center. The clinic is staffed by Jessica Colyer, MD, and Jodi Pike, MD. Telemedicine also is available from Reston to Children's National's main campus, including echocardiography and ECG reading.

Children's National Cardiology
1800 Town Center Dr., Suite 401
Reston, VA 20190
Appointments: 202-476-2090

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New *Faculty*

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Endocrinology and Diabetes
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Michelle Lin, MD

Epilepsy and Neurophysiology
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Gastroenterology, Hepatology, and Nutrition
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General Pediatrics
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Christine Briccetti, MD
Melissa Long, MD
Jessica Nash, MD

Genetics and Metabolism
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Hematology/Oncology
Jeffrey Knipstein, MD

Hospitalist Medicine
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Gina Gallizzi, MD
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Michael Mintz, PsyD
Aaron Rakow, PhD
Sharon Singh, PhD

Pulmonary Medicine
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Sarah Zaidi, MD

Rheumatology
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Tova Ronis, MD

A One-On-One with Timothy Kane, MD

Chief of the Division of General and Thoracic Surgery

Timothy Kane, MD, is the new Chief of the Division of General and Thoracic Surgery at Children's National Medical Center. Dr. Kane came to Children's National in August 2010 as Associate Chief of Clinical Affairs and Program Director of the Pediatric Surgery Fellowship Program. He helped develop the center's minimally invasive surgery program through clinical practice, instruction, and research. Dr. Kane has worked to improve minimally invasive surgical techniques and speed its incorporation into standard clinical care for pediatrics.

Dr. Kane is nationally and internationally recognized as a leader in pediatric minimally invasive surgery (MIS) and has published extensively on innovative techniques and approaches in MIS in infants and children. He is on the executive committee of the International Pediatric Endosurgical Group, the premier organization worldwide concerning MIS in children, on which he serves as the "Americas Representative". As the director of the Fellowship Program in Pediatric Surgery, Dr. Kane and his team have made it one of the best, if not the best, program in the country.

Q: In your new role as Chief of General and Thoracic Surgery, what would you like pediatricians to know about your division?

A: It's an exciting time because we have a core group of great surgeons and physicians. It's an honor to have this group assembled because I think each of us has a focused area that we want to pursue, whether it be Evan Nadler, MD, with obesity, or Anthony Sandler, MD, who is now the Senior Vice President of the Joseph E. Robert, Jr., Center for Surgical Care. We all have a solid clinical background and by tapping into the skills of everyone, we have a team that's second-to-none in terms of patients who can be referred. Our training program is one of the most highly sought after programs in the country.

Q: Can you briefly explain what minimally invasive surgery means and what kind of patients typically need this approach?

A: Minimally invasive surgery is an approach to performing a surgical procedure where you can use smaller incisions to access a particular part of the body such as the chest cavity or abdominal cavity. In many settings, I think a lot of patients can benefit from this approach because it's less invasive, there is less pain with the operation, less scarring, and there's also a shorter recovery time. Anyone from a neonatal patient to an adult can benefit; it just depends on what procedure is performed.

Q: Are there times when a minimally invasive approach is not appropriate for a patient's treatment?

A: Yes, there are kids who may have very large tumors and removing the tumor would require a sizable incision. You don't want to compromise the oncologic surgery by trying to do something that doesn't make sense. Also, in some trauma situations, it is generally not indicated to take a minimally invasive approach.

Q: Has the percentage of minimally invasive procedures increased over the past few years? Are more surgeons taking this approach versus bigger operations with bigger incisions?

A: Yes, I believe it has. A good example is the majority of appendectomies are done minimally invasively now. Some of the more difficult procedures, like those on neonates, are more challenging, and should be performed in facilities where the physician has ample training. I lead our neonatal surgery team at Children's. There's a hard learning curve because it's harder to train pediatric surgeons.

Q: Looking into the future, do you see minimally invasive surgery changing? If so, how? Are there any particular technologies that you find encouraging or transformational?

A: I think one of the areas that is going to be a big advantage in minimally invasive surgery is 3D. 3D laparoscopy is now used in robotic surgery, but not in conventional laparoscopic or thoracoscopic surgery, which uses 2D. At Children's National, a 3D camera is now being used in some cases. The visualization is tremendous! The one issue with the robot is that the instruments are really big, so for babies it's hard to adapt the robot for surgery on kids. I don't use it if I have to make bigger incisions than I normally would need for laparoscopies. Some of the 3D imaging and some of the ultrasound imaging we use can fuse the ultrasound image to the laparoscopic image and we see it in 3D. That's an innovation in the field of pediatric surgery.

... continued on page 4.

MR-I Can Do It Program

Imaging Children Without Sedation—A New Radiology Program

By Tracy Sharbaugh, CCLS

The Children's National Department of Radiology and Diagnostic Imaging along with Child Life, has launched the **"MR-I CAN DO IT"** program to help children ages six and older undergo magnetic resonance imaging (MRI) without sedation. In most pediatric imaging facilities, patients younger than eight years old are automatically scheduled to receive anesthesia sedation to successfully complete a 60-minute MRI exam.

Although anesthesia sedation is an extremely safe process and offers many benefits, some of our families were interested in other options.

What We Offer

The MR-I Can Do It program involves screening of potential non-sedate candidates at the moment of scheduling, which is followed by further assessment of the child's ability to succeed in the program. Patients or families receive a wide array of education material and coaching via phone by radiology child life specialists to prepare for the MRI. On the day of the exam, the child life specialists greet and work with the child and family. A special play area in the MRI suite enhances the child's understanding of an MRI, which includes MRI sounds and a mini MRI scanner that can be used for demonstrations and doll play. During the MRI, we offer Cinemavision movie goggles or iPod music to provide distraction and relaxation to the children in hopes to increase their coping and reduce anxiety and movement.

More than 100 patients have successfully completed MRI scanning without sedation as part of the MR-I Can Do It program.

Locations: This program is offered at both Children's National's Sheikh Zayed campus as well as the outpatient imaging location at the Montgomery County Regional Outpatient Center.

Contact: If you think your patient can do a non-sedated scan for 60 minutes or is interested in learning more about this program, contact Radiology Child Life at 202-476-3338.

From page 3: # A One-On-One with Timothy Kane, MD

Q: As a pediatrician, if a family asks about minimally invasive procedures, what advice would you recommend?

A: I would say that they probably should discuss options with a pediatric surgeon who has done the procedure, so the surgeon can explain the risk and benefits and give them options. Not everything can be done minimally invasively and it's sometimes even hard for surgeons to figure out what is appropriate. It would be a lot to ask a pediatrician to make a recommendation on the course of care. To help answer questions, I am always willing to consult if someone has a question about suitability for minimally invasive surgery.

To discuss a patient with Dr. Kane, email him at: TKane@childrensnational.org.

Children's National Study Demonstrates Effectiveness of New Bariatric Surgery Procedure In Adolescents

By: Evan Nadler, MD; Co-Director, Children's National Obesity Institute

Overview

Obesity has been clearly identified as one of the most important public health concerns in children and adolescents, and the costs of care continue to mount in parallel with the prevalence of the disease. Obesity prevention remains the essential long-term strategy to combat the epidemic, but promising interventions are either too expensive or require more robust data to support their use and thus have not been universally implemented. Compounding the problem is the fact that the most comprehensive and aggressive multidisciplinary weight management programs have shown only modest weight-loss results in the populations that are most severely afflicted. Thus there has been increasing interest in bariatric surgery for adolescent patients with morbid obesity, although some have argued that perhaps too much enthusiasm has been devoted to this treatment option without sufficient long-term follow-up.

Due to the relatively high morbidity and mortality associated with gastric bypass, and the lack of approval by the U.S. Food and Drug Administration for laparoscopic adjustable gastric banding in patients less than 18 years of age, we have begun to explore laparoscopic sleeve gastrectomy (LSG) as a procedural option for adolescents who are morbidly obese. LSG has become an accepted surgical alternative for adults with morbid obesity, and its popularity among adult centers is increasing.

Study Details

All patients who have undergone LSG at Children's National since the inception of our weight-loss surgery program in January 2010 were entered into our prospective database and retrospectively reviewed. The patients met the NIH consensus development conference criteria for bariatric surgery in adults.

Patients more than 18 years of age were offered either LSG or laparoscopic adjustable gastric banding (LAGB), patients younger than 18 years of age all received LSG but were offered the choice to wait until 18 when LAGB could be performed.

All of the procedures were performed either by two attending pediatric surgeons in concert or via a single attending and a resident or fellow. Patients were discharged once they had achieved adequate oral intake, their pain was under control, and they were ambulating without difficulty.

A strict post-operative nutritional regimen was employed that consisted of a liquid diet for the first 2 weeks, with gradual increases in food texture over the ensuing three months. After 3 months, drinking beverages at the time of eating food was permitted.

Patients returned to the office for evaluation 2 weeks after surgery, and then every three months for the first post-operative year to monitor weight loss, appetite, dysphagia or food intolerance, eating behavior, comorbidity status, and the presence of any complications. Follow-up was then decreased to every 6 months after the first year.

Results

From January 2010 to December 2011, 23 patients ages 14-19 have undergone LSG at our institution for the treatment of morbid obesity. The cohort consisted of 5 males and 18 females.

There were 13 African American patients (56 percent), 5 Hispanic patients (22 percent), and the other 5 were Caucasian (22 percent).

The mean age was 17.3 ± 1.5 years with a mean initial weight of 149 ± 30 kg and a mean initial BMI of 52 ± 9 kg/m2. All operations were performed via a laparoscopic approach and the mean length of stay was 2.2 ± 1.1 days. Detailed weight loss data are presented in the table below.

Time	Number of Patients	Mean Weight (kg)	Mean BMI (kg/m2)	% Excess Weight Loss
Pre-op	23	149 ± 30	52 ± 9	NA
3 months	22	122 ± 29	42 ± 9	32 ± 13
6 months	13	119 ± 32	40 ± 8	38 ± 14
9 months	10	117 ± 33	40 ± 11	40 ± 23
1-year	9	119 ± 36	39 ± 8	40 ± 19

More important than the absolute weight loss is the impact of the weight loss on patient co-morbid conditions. At baseline, our 23 patients suffered from a total of 64 obesity-related co-morbid conditions.

Impaired glucose tolerance, whether it be insulin resistance or Type 2 diabetes (n=14), was the most commonly reported co-morbid condition at baseline, followed by obstructive sleep apnea (n=12) and hypertension (n=8). Nine patients who have reached one-year follow up had a total of 22 preoperative comorbidities. At one year follow-up, 12 of the 22 (55 percent) co-morbid conditions were completely resolved, and 5 (22.5 percent) were improved.

To read the full study and learn more about Children's Bariatric Surgery Program, visit: **www.ChildrensNational.org/ObesityInstitute**.

Partnering With The Referring Community

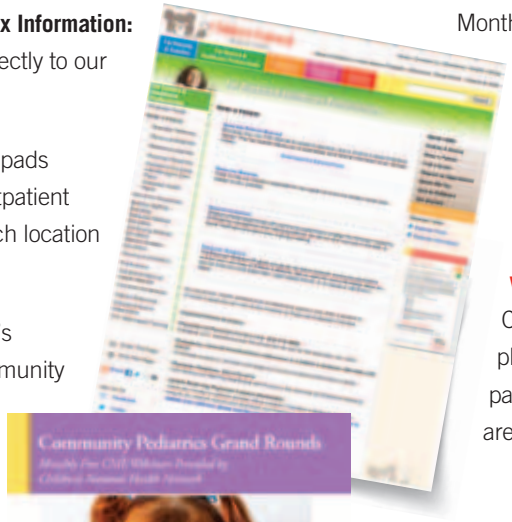
Referral Resources—Online

Children's National is constantly working to increase the resources available to your practice online. Here are some direct links you can bookmark to easily access Children's services.

www.ChildrensNational.org/Refer

This landing page offers quick links to the following resources:

- **Specialty Referral Request Fax Information:** You can now fax referrals directly to our contact center.
- **Resource Materials:** Referral pads for Maryland and Virginia outpatient centers with directions to each location in Spanish and English.
- **Referral Guidelines:** Children's National partnered with community pediatricians to adapt the American Academy of Pediatrics management and referral guidelines to assist healthcare providers when making a referral. For example, the guidelines include specifics for the following divisions: Gastroenterology, Orthopaedic Surgery, and Headache Program.
- **Physician Relations:** Learn about the Liaison team who is available to meet with your practice and introduce your team to Children's specialists.



www.ChildrensNational.org/CNHN

Children's National Health Network is one of the country's largest dedicated pediatric provider networks.

CNHN brings together more than 1,400 community-based pediatricians in our region with the pediatric specialists, programs and services at Children's National.

CNHN improves regional pediatric care and collaboration through group business, educational and quality improvement initiatives.

Monthly Community Pediatric Grand Rounds are archived here and are available for CME credit.

September's "Birds, Pigs & Kids, Oh My! ***(ID Update on West Nile Virus, Swine Flu and Pertussis for Frontline Pediatricians)"*** presented a timely topic and provided information you can use now in your practice.

www.ChildrensNational.org/Gateway

Children's National Gateway is our resource for referring physicians who would like real-time information on their patients referred to Children's National. Included in the portal are physician consult notes, and radiology and lab results.

Northern Virginia *Regional Outpatient Center and Neurosurgery Office*

To better meet the needs of patients and families, the Children's National Medical Center Northern Virginia Regional Outpatient Center (ROC) and Neurosurgery office have moved to a new, state-of-the-art facility.

Northern Virginia Regional Outpatient Center
3023 Hamaker Ct
Suite 300, Third Floor
Fairfax, VA 22031
571-226-8380/1-800-787-0467
571-405-5700 (f)

Division of Neurosurgery
3023 Hamaker Ct
Suite 450, Fourth Floor
Fairfax, VA 22031
571-226-8330
571-405-5900 (f)

Other Outpatient Centers

- Children's National Specialists of Virginia, LLC
  **An affiliated private practice*
- Children's Center for Cancer and Blood Disorders of Northern Virginia
- Annapolis Regional Outpatient Center
- Upper Marlboro Regional Outpatient Center
- Montgomery County Regional Outpatient Center, Ambulatory Surgery Center, Neuropsychology, and Children's National Imaging
- Frederick Regional Outpatient Center
- Spring Valley Regional Outpatient Center
- Laurel Regional Outpatient Center

Specialty services offered at the **Northern Virginia Regional Outpatient Center and Neurosurgery Office** include:

SPECIALTY	SPECIALIST
Adolescent Medicine	Tomas Silber, MD
Allergy	Darlene Mansoor, MD Cindy Nguyen, MD
Cardiology	Charles Berul, MD Jessica Colyer, MD Mary Donofrio, MD Lowell Frank, MD Linda Leatherbury, MD Jeffrey Moak, MD Jodi Pike, MD Roger Ruckman, MD Michael Slack, MD
Developmental Pediatrics	Jacquelyn Calbert, MD Susan Pratt, MD
Endocrinology and Diabetes	Allison Boyce, MD Fran Cogen, MD Paul Kaplowitz, MD Rinku Mehra, MD Priya Vaidyanathan, MD
Genetics and Metabolism	Brendan Lanpher, MD Pranoot Tanpaiboon, MD
IDEAL Clinic	Nailah Coleman, MD Jean Limpert, MD
Nephrology	Kanwal Kher, MD Shamir Tuchman, MD
Neurology	Taeun Chang, MD Lucy Civitello, MD Emily Freilich, MD Rhonda Franke, NP Ana Gelabert, NP Jonathan Hecht, MD, PhD Bennett Lavenstein, MD William McClintock, MD Phillip Pearl, MD
Neurosurgery	Suresh Magge, MD John Myseros, MD
Pain Clinic	Sarah Rebstock, MD Angela Fletcher, PhD
Psychiatry/Psychology	Michelle Dadson, PhD Bhavin Dave, MD Lisa Efron, PhD Maureen Monaghan, PhD Adelaide Robb, MD
Pulmonary Medicine	Suja Nair, MD Iman Sami, MD Cathie Wiggins, NP

Children's National Medical Center

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Washington, DC 20010

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Visit us on the web at www.ChildrensNational.org

People *in the News*

Andrea Gropman, MD, has been named the Chief for the Division of Neurodevelopmental Disabilities and Neurogenetics. Dr. Gropman specializes in neurogenetics, with a focus on mitochondrial disorders and Smith Magenis syndrome. She received her medical degree from the University of Massachusetts Medical Center Medical School and held residencies at Johns Hopkins University School of Medicine and George Washington University. Dr. Gropman was previously a Neurology Fellow at Children's National.

Marc DiFazio, MD, joined the neurology practice in the Montgomery County Regional Outpatient Center on October 1, 2012. Prior to Children's National, Dr. DiFazio served as Chief of Child Neurology at Walter Reed Army Medical Center until 2005, and most recently has been in private practice on the Shady Grove campus in Rockville. He has widely recognized expertise in clinical child neurology, with particular emphasis in the areas of Tourette syndrome, headache/migraine, concussion and sports neurology, and the use of botulinum toxin (Botox) for a variety of conditions including headache, spasticity, and sialorrhea.

Dr. DiFazio also will be taking on the position of **Medical Director** for the Montgomery County Regional Outpatient Center, and will be responsible for overseeing all medical and surgical services at this location, while serving as an accessible liaison for community clinicians. Additionally, Dr. DiFazio will see patients at the Children's Outpatient Center in Frederick, Md.

Questions or concerns regarding the Rockville Outpatient Center can be directed to Dr. DiFazio directly at 301-765-5633, or at **mdifazio@childrensnational.org**. In addition, Children's Physician Relations team is available at 202-476-4418 to help assist with other locations and pediatric specialty care.