Welcome to the second edition of Pediatric Pulse, a Kentucky Children’s Hospital newsletter especially for referring providers. In this quarterly newsletter we provide updates on the happenings at Kentucky Children’s Hospital in addition to information on new or interesting services we offer.

We are excited about the new Kentucky Children’s Hospital Congenital Heart Clinic that opened Oct. 3. For the first time our pediatric heart patients will be able to get all of their services from cardiologists and CT surgeons in one location. We welcome you to visit this clinic when in town; our liaisons can arrange a tour.

Also in this issue, Jamshed Kanga, MD, gives a brief overview of laryngomalacia with suggestions on diagnosis and management and when a consultation can be beneficial.

As an aside, the Pediatric Pulmonary Clinic will be expanding its pulmonary function testing lab in the near future.

I want to once again remind you that numerous Kentucky Children’s Hospital records are now available through the physician portal. The most utilized information to date is the online discharge notes from the newborn nursery and units, along with lab results and procedural notes. More and more daily progress notes are also being made available online. Our liaisons will be glad to instruct you or your office staff in accessing the portal.

As stated in the last issue, we are continuing to focus on improving communication with our referring providers. In the meantime, if you have trouble getting in touch with your patient’s attending physician, please contact me through UK•MDs (toll free 1-800-888-5533) or email at cwall4@uky.edu.

Carmel Wallace, MD, Interim Chair, Department of Pediatrics
Division Chief, General Academic Pediatrics, Kentucky Children’s Hospital

Be Amber Alert ready

More than 3,000 children are reported missing every day in the U.S. Ensure you are prepared for emergencies by getting free biographical documents for your children from Kentucky Children’s Hospital and Child Safety USA.

Each child's photo and fingerprints will be captured and assembled onto a high-quality 8 ½ x 11 inch biographical document and given to parents. The Amber Alert-ready document can be provided to law enforcement to aid in the recovery of a missing child.

NOTE: No database or records of children are maintained. The only record of the visit will go home with the parent for safekeeping.

When: Saturday, Nov. 12, 9 a.m. – 4 p.m.
Sunday, Nov. 13, 9 a.m. – 4 p.m.
Where: UK Chandler Hospital, First floor, Between Pavilion A and Pavilion H
1000 S. Limestone, Lexington

For information, call 859-257-1000 or 1-800-333-8874 (toll free).
In our commitment to provide the highest quality of care in a timely manner, Kentucky Children’s Hospital has instituted a new acuity trigger for automatic launch of our air medical pediatric critical care transport team before you even speak with a physician. If your patient meets certain criteria as developed by the neonatology and pediatric critical care division, our transport team will be dispatched when you call UK•MDs, just as the accepting physician is being paged.

We are tracking the success of this program and hope to expand it in the coming months. In addition, we value your time as referring physicians and will make sure that our physicians are on line with you in less than five minutes. If you have any further questions, feel free to contact Emergency Transport Manager Shelly Marino at 859-257-4678 or srmari2@uky.edu.

**Introducing Kentucky Children’s Hospital Congenital Heart Clinic**

As of Monday, Oct. 3, all pediatric heart services were consolidated into one convenient location to provide improved continuity of care, customer service and access.

Consultation and follow-up care will be provided for:
- Cardiology
- CT surgery
- Adult congenital heart disease
- Hypertension
- Lipid disorders and obesity

The new clinic has a state-of-the-art diagnostic center featuring the following:
- Echocardiography
- EKGs
- Holter and event monitors
- Stress echos
- Fetal echocardiography
- Pacemaker evaluations and management

The new clinic is located on the second floor of the Kentucky Clinic. For more information or to refer a patient, call UK•MDs at 859-231-9922 or 1-800-888-5533 (toll free).

**Physician Liaison Program**

The Physician Liaison Program works to improve service to providers who refer patients to UK HealthCare physicians, hospitals and clinics. The team’s role is to facilitate communication between you – the referring physician – and our physicians and staff so you get the access and information you need. If you have questions or would like to schedule portal training, contact Tarra Crane at 859-559-7602 or tlcran2@email.uky.edu.
Laryngomalacia

Jamshed F. Kanga, MD
Chief, Pediatric Pulmonary Medicine

What is laryngomalacia?
Laryngomalacia is a softening of the tissues of the larynx (voice box) above the vocal cords. This softening causes the tissues to become floppy and partially block the airway, resulting in noisy breathing. Laryngomalacia is the most common cause of stridor in infancy.

What causes laryngomalacia?
Laryngomalacia symptoms are usually present at birth and can become more obvious within the first few weeks of life. It is not uncommon for the stridor to get worse before it improves, usually around 4 to 8 months of age. Most children outgrow laryngomalacia by 18 to 20 months of age.

Signs of laryngomalacia:
- High-pitched inspiratory stridor that is often worse when the baby is agitated, feeding, crying or sleeping on the back.
- Suprasternal and subcostal retractions.
- Poor weight gain.
- Choking and difficulty while feeding.
- Gastroesophageal reflux.
- Aspiration of food into the lungs is uncommon.
- Obstructive apnea and cyanosis are rare.

Is laryngomalacia a serious condition?
In 99 percent of infants, laryngomalacia is not a serious condition – they do not have serious breathing problems and are able to eat and grow. For these infants, parents can be reassured the laryngomalacia will resolve by the time the child is 18 to 20 months of age. However, a small percentage of babies with laryngomalacia have symptoms needing prompt attention.

How is the diagnosis of laryngomalacia made?
The diagnosis of laryngomalacia is usually made by history and examination of the infant. The best way to confirm the diagnosis of laryngomalacia is by laryngoscopy or bronchoscopy. This test is best performed with the baby sedated to avoid pain and to ensure cooperation. Since most infants improve with time, this procedure is only recommended for some infants.

Primary care interventions:
- Most infants do not require any treatment, but parents need education and reassurance.
- Since feeding problems and GE reflux are fairly common, careful feeding and antireflux precautions need to be addressed with family.
- Occasionally acid-suppression therapy helps.
- When the infant is congested, suctioning nares with bulb syringe will help with feeding.
- Avoid contact with persons who have colds and flu-like symptoms.
- Routine immunizations are essential.
- Inhalation therapy with bronchodilators and inhaled steroids do NOT help in laryngomalacia and should not be prescribed.

Infants with any of the following qualities should be referred for laryngoscopy or bronchoscopy:
- Severe respiratory symptoms and stridor.
- Apnea or cyanosis.
- Significant trouble feeding or failing to thrive.
- History of intubation or instrumentation of the airway.
- Anomalies such as hemangiomas or tumors on the face and neck.
- Noisy breathing that began suddenly after 6 months of life (think foreign-body aspiration).
- Symptoms persist beyond 18 months of age.
- Unusually anxious families.

To refer a patient to the Pediatric Pulmonary Clinic, call UK•MDs at 1-800-888-5533. To contact the clinic directly, call 859-323-6211.

Community Corner

Make plans to attend our May 16 Communitywide Pediatric Morning Report meeting. These meetings are held the third Wednesday of May and September. Their goal is to increase face-to-face communication. We are always in need of cases from the community to present and discuss. If you have new cases or concerns to discuss, please call Katrina Hood, MD, at 859-277-6102.
Meet our new physicians

We are pleased to welcome four new physicians to the UK HealthCare team.

Scottie B. Day, MD
Critical Care

Dr. Day completed his undergraduate studies in biology at UK, where he also earned a medical degree. He served as a resident at a variety of hospitals in Indianapolis, including Indiana University, Wishard Memorial Hospital, Riley Hospital for Children, Methodist Hospital and Veterans Administration Hospital. He completed his critical care and research fellowship at Cincinnati Children’s Hospital.

Most recently Dr. Day has worked as a pediatric intensivist with the Hawaii Permanente Medical Group for the Department of Pediatrics at Kaiser Moanalua Hospital in Honolulu.

A native of Hyden, Ky., Dr. Day is excited to return to his home state as the new director of pediatric transport and outreach.

Janeth Ceballos Osorio, MD
General Pediatrics

Dr. Osorio received her medical degree from the Universidad del Valle, Colombia, where she continued with her residency in family medicine until 2001. She later completed a residency at UK Pediatrics. Dr. Osorio is bilingual in English and Spanish.

Stephanie Stockburger, MD
Adolescent Medicine

Dr. Stockburger earned her undergraduate degree at Eastern Kentucky University in 2004. She obtained her medical degree at UK in 2008 and completed a categorical pediatrics residency at UK HealthCare.

Sthorn Thatayatikom, MD
Allergy and Immunology

Dr. Thatayatikom received her medical degree from Thammasat University in Bangkok, Thailand, in 1998. She completed a pediatric residency at SSM Cardinal Glennon Children’s Medical Center in St. Louis and an allergy and immunology fellowship at the Saint Louis Children’s Hospital and Barnes-Jewish Hospital.

Dr. Thatayatikom has published in several academic journals and is a member of the American Academy of Allergy and Immunology, American College of Allergy and Immunology, and American Academy of Pediatrics.

Keeping children safe

New official AAP recommendations on child safety seats (CSS)

The newest child passenger safety recommendations developed by the American Academy of Pediatrics (AAP) are clear and concise in encouraging slowing the transition from one child restraint type to the next. Read the five best-practice recommendations below.

1. All infants and toddlers should ride in a rear-facing child safety seat (CSS) until two years of age or until reaching the highest weight or height allowed by the manufacturer of their CSS.

2. All children two years or older, or those younger than two years who have outgrown the rear-facing weight or height limit for their CSS, should use a forward-facing CSS with a harness for as long as possible, up to the highest weight or height allowed by the manufacturer of their CSS.

3. All children whose weight or height is above the forward-facing limit for their CSS should use a belt-positioning-booster until the vehicle lap-and-shoulder seat belt fits properly, typically when they have reached 4 feet 9 inches in height and are between eight and 12 years of age.

4. When children are old enough and large enough to use the vehicle seat belt alone, they should always use lap-and-shoulder seat belts for optimal protection.

5. All children younger than 13 years of age should be restrained in the rear seats of vehicles for optimal protection.

A large number of child restraints with high weight harnesses and taller seat backs have been available for some time in the U.S. market. Parents may have already purchased a high-weight harness seat without realizing the true benefit of it.

To learn more, visit safekidsfayecounty.com or find us on Facebook!