



The Forum

NEWSLETTER OF THE MASSACHUSETTS CHAPTER AMERICAN ACADEMY OF PEDIATRICS

PRESIDENT'S MESSAGE

Birth Defects Forms to Fill Out

Oh no, not one more form to fill out! I simply don't have the time. Somebody else should do it.

This is part of a much larger issue, though, and one that all of us should be interested in thinking about — moments a day at least. We see too many runny noses, too many disobedient toddlers, too many opinionated parents. Where are the real issues? How can we make a real difference, as we used to dream of doing?

Well, there seem to be serious increases in asthma, autism, ADHD, and other medical and behavioral conditions out there. And we have too few clues as to why. We know a good deal about lead poisoning, but only now, more than a hundred years into our concern about this problem, have we discovered that even very low levels of this simple, divalent cation can cause significant cognitive and behavioral damage. To discover this, it takes studies tracking children across decades of their lives. We studied the toxic effects of Agent Orange because we knew it was a bioactive weapon, but its toxicity continues to become apparent decades after exposure. Why are some people affected and others not at all?

We are identifying these problems for a variety of reasons: 1) We have become better at recognizing and diagnosing them — autism or OCD in children, for instance; 2) We are reporting them more diligently; 3) We are paying attention to more subtle behavioral states; 4) There are more people looking at levels of environmental

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MCAAP Committee Updates

Pediatric Council

There have been many coding and procedural updates with the various health plans in Massachusetts. The following is a brief summary of some of the changes:

Blue Cross/Blue Shield

As of September 1, 2003, BCBS will accept the modifier -25 with a preventive care visit, reimbursing the E&M code at 50% of their fee schedule. Separate documentation for the complaint is required. Also, as of September 1, 2003, BCBS will accept the 99054 Sunday/Holiday CPT code. The 99050 code for visits after 5 p.m. is still under consideration. BCBS is also performing a pilot with RelayHealth that allows physicians to bill the insurance plan for secure e-mail consultations with patients.

MassHealth

With the large state budget cuts, there are significant reimbursement changes this year. Payments for sick visits have been decreased by 4%, but newborn and preventive care visits are exempted. Reimbursement for PNPs billed under their own MassHealth number has been decreased 15%. Patients covered by the SCHIP program (>133% poverty) will now be required to pay \$3 copays. Efforts are ongoing to exempt pediatric offices from these changes. MassHealth has instituted a list of drugs that require prior authorization. If there are medications you feel should not require prior authorization, please contact Walter Harrison at wharrison@mcaap.org.

Tufts

Tufts has begun to accept the 99371-3 series of telephone consultation codes. Although the CPT book describes broad usage for this code, Tufts has intended that this code be used for case management and care coordination only, particularly for children with special health

care needs. Overuse of these codes would probably flag a practice for a chart audit.

– Walter Harrison, M.D.

Membership Committee

The American Academy of Pediatrics (AAP) Board of Directors met in mid-May 2003. The following issues were addressed:

A) The recommendation to eliminate the seven-year limit on Candidate Fellows was accepted. This allows Candidate Fellows to stay involved and benefit from AAP educational activities, etc. The dues for the Candidate Fellows reach full dues in year five.

B) The medical student program received renewal funding from the Friends of Children Fund. Medical student benefits will be expanded to include an electronic subscription to AAP Grand Rounds. The Board also agreed to lower medical student dues from \$30/year to \$15/year. An additional component of the medical student program will be the “incentive grants” to Chapters to build relationships with local Clerkship Directors and sponsor medical student activities. Please let me know of any programs already in existence, or any which will be starting up, so that recognition and perhaps financial help can be obtained by the Chapter leadership.

C) AAP President Steve Edwards took the American Board of Pediatrics (ABP — an organization entirely separate from the AAP, as many of you know) to task on the issue of proctored recertification exams. This method of recertification has been perceived by membership in all districts as punitive and expensive and not as an educational process. Dr. James Stockman from ABP has been invited to the AAP Forum in September, so district officers can present questions and objections to this recertification issue. Get your questions

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MASSACHUSETTS CHAPTER
 AMERICAN ACADEMY OF PEDIATRICS
 PO Box 9132, Waltham, MA 02454-9132

Chapter Administrator

Cathleen Haggerty
 (781) 895-9852; Fax: (781) 895-9855
 E-mail: chaggerty@mcaap.org

Forum Editor

David Chung, M.D.
 E-mail: dchung@mcaap.org

Chapter President

Sean Palfrey, M.D.
 Boston (617) 414-5202; Fax: (617) 414-4541
 E-mail: spalfrey@mcaap.org

Vice-President

Lynda Young, M.D.
 Worcester (508) 752-4511; Fax: (508) 797-4729
 E-mail: lyoung@mcaap.org

Treasurer

Paul C. Schreiber, M.D.
 Brockton (508) 894-0618; Fax: (508) 894-0618
 E-mail: pschreiber@mcaap.org

Secretary

Carole Allen, M.D.
 Arlington (781) 643-7155; Fax: (781) 643-0540
 E-mail: callen@mcaap.org

Legal Counsel

Edward Brennan, Esq.
 Kirkpatrick & Lockhart, Boston (617) 951-9143

District 1

David Sigelman, M.D.
 Holyoke (413) 536-2393; Fax: (413) 536-1087
 E-mail: dsigelman@mcaap.org

District 2

David Norton, M.D.
 Ware (413) 967-2040; Fax: (413) 967-2044
 E-mail: dnorton@mcaap.org

District 3

Julie Meyers, M.D.
 Uxbridge (508) 278-5573; Fax: (508) 278-7142
 E-mail: jmeyers@mcaap.org

District 4

Joel Bass, M.D.
 Newton (617) 243-6000; Fax: (617) 256-1565
 E-mail: jbass@mcaap.org

District 5

Sheila Morehouse, M.D.
 Chelmsford (978) 256-4363; Fax: (978) 256-1565
 E-mail: smorehouse@mcaap.org

District 6

Cheryl Kerns, M.D.
 Marblehead (781) 631-7800; Fax: (781) 631-4319
 E-mail: ckerns@mcaap.org

District 7

Megan Sandel, M.D.
 Boston (617) 638-8000; Fax: (617) 414-3679
 E-mail: msandel@mcaap.org

District 8

Michael Yogman, M.D.
 Cambridge (617) 864-7071
 E-mail: myogman@mcaap.org

District 9

Jordan Leff, M.D.
 Brockton (508) 894-0400; Fax: (508) 894-0618
 E-mail: jleff@mcaap.org

District 10

Margaret Carolan, M.D.
 Cohasset (781) 383-6800; Fax: (781) 383-6504
 E-mail: mcarolan@mcaap.org

What Is the MCAAP Doing for You?

David Chung, M.D.

In the last issue of the *Forum*, we promised you a tool to help you adhere to insurance plan formularies. By using this tool, you can provide your patients with excellent care at a lower cost to your patients and the health plans.

Pages 5 through 11 of this issue contain the MCAAP Formulary Guide. The first four pages list five insurance plans and drugs by therapeutic category. Refer to these pages for tier information on particular drugs. The last three pages list each medication and provide formulations and standard dosages. Please keep in mind this is the first published draft of the MCAAP formulary guide. Although great pains were taken to provide accurate information, it is likely there are mistakes.

I would like to thank the first five plans that participated for their gracious assistance. Without their help, the MCAAP could not have provided this tool for your use. If you would like to see other major plans included, please contact the pediatric medical director for that plan to

encourage them to participate.

In addition to the print copy, there will be an electronic version available at www.mcaap.org. If there is sufficient interest, we may also send this tool to you via our fax-messaging system.

We recommend that you leave a



double-sided copy with each page in a plastic sheath in each examination room for easy reference. We would like your feedback on the MCAAP formulary guide — its ease of use, accuracy, and limitations. Please do not hesitate to e-mail your opinion to chaggerty@mcaap.org.

Reminder from LDAM

The Learning Disabilities Association of Massachusetts (LDAM) would like to remind you that you should have received materials on learning disabilities in the month of June. If you have any questions, or would like more information, please contact Teresa Citro at (781) 891-5009. You can also visit the LDAM website at www.ldam.org.

MCAAP COMMITTEES & ADMINISTRATIVE APPOINTMENTS

AAP Breastfeeding Coordinators Susan Browne Jean Sheeley	Emergency Pediatric Services Patricia O'Malley	International Child Health Open	Nominating Committee Eugenia Marcus
Bylaws Committee Carole Allen	Environmental Hazards Open	Legislation Alan Meyers	Nutrition Open
CATCH Co-Coordinators Robert Kossack Emily Roth	Fetus & Newborn Elizabeth Brown	Massachusetts Healthy Families Howard King	Pediatric Council Walter Harrison
Child Abuse & Family Violence Robert Nelken	Forum Editor David Chung	Membership Patricia Moffatt	Pediatric Practice Open
Committee on Adolescence Harris Faigel	Foster Care Linda Sagor	Mental Health Task Force Walter Harrison Eugenia Marcus	PROS Network Coordinators Hank Bernstein Ben Scheindlin
Continuing Medical Education Lynda Young	Immunization Initiative Sean Palfrey Hadassa Kubat	MMS Delegate/House of Delegates Carole Allen	School Health Linda Grant
Developmental Disabilities Richard Antonelli	Infectious Disease Sean Palfrey	MMS Interspecialty Committee Representatives Carole Allen Sean Palfrey	Substance Abuse Open
	Injury Prevention & Poison Control Paul Schreiber		Technology David Norton William Adams

FORUM JOB LISTINGS

LOOKING FOR POSITION:

Name: Dorothy J. Ganick, MD
Contact: (978) 526-9833 (home)
Residency: Pittsburgh Children's Hospital
1971-1974
Fellowship: Strong Memorial Hospital
Rochester (pediatric hematology/
oncology)
1974-1976
Availability: Immediately for part-time
position
Comment: Interested in part-time position
within 1 hour drive of Manches-
ter, Massachusetts. Background in
hematology/oncology as well as
pediatrics. Currently working for
locum tenens agency.

Looking to Hire or Be Hired?

Job listings are a free service provided by *The Forum* to MCAAP members and residents completing their training. Nonmembers may submit ads for a fee.

If you are looking to fill a position

MCAAP members: Free

Nonmembers: \$250

Please submit the following information:

- Practice Name
- Position Title and Description (25-word limit)
- Availability (e.g., starting July 2003)
- Contact Name
- Address, Telephone Number, E-mail Address

If you are looking for a job

MCAAP members and residents: Free

Nonmembers: \$50

Please submit the following information:

- Your Name
- Contact Information
- Residency Program
- Availability (e.g., available now)
- Comment (25-word limit)

Please send text information via e-mail to dchung@mcaap.org. Checks may be mailed to the MCAAP office, c/o Cathleen Haggerty, Executive Director, P.O. Box 9132, Waltham, MA 02454-9132. All submissions must be received by September 15, 2003, to be included in the next issue of *The Forum*. All submissions are subject to review for appropriateness. For further information, please contact the editor at dchung@mcaap.org

New MCAAP Officers Elected

Congratulations to the following new directors:

District 4, Joel Bass, M.D.

District 5, Sheila Morehouse, M.D.

District 6, Cheryl Kerns, M.D.

District 7, Megan Sandel, M.D.

District 10, Margaret Carolan, M.D.

Individual Varicella Case Reporting Coming Soon

By Stephanie Schauer

Since the licensure of the varicella vaccine in 1995, the number of cases of varicella in Massachusetts has significantly decreased. To gain a better understanding of the epidemiology of varicella in the post-vaccine era, the Centers for Disease Control and Prevention expect all states to have individual case-based reporting in place by 2005. Massachusetts is moving in this direction and, by early 2004, will initiate such individual reporting.

- ★ A current draft of the one-sided form includes basic demographic information, limited clinical information, and vaccination history.
- ★ Providers and school nurses will be expected to fill out the case-report form.
- ★ The forms will be submitted by providers via confidential fax to the Massachusetts Department of Public

Health Immunization Program (MIP) with their varicella vaccine orders, as is currently being done with the aggregate reporting system now in place for varicella.

- ★ Information on cases will be shared with the local boards of health.

This individual reporting will allow better ascertainment of cases and allow a greater understanding of the impact of immunization on disease incidence, morbidity and mortality, as well as help to detect vaccine failures. In addition, breakthrough disease can be carefully monitored and evaluated. Providers, local boards of health, and schools all play an important role in reporting, and the MIP would like to continue to hear about any unusual cases or situations involving varicella. For more information, or to make a report, the MIP can be reached at (617) 983-6800 or toll-free at (888) 658-2850.

MCAAP Committee Updates

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in to me, so your voice can be heard — remember

*The Louder the Lion ROARRRRS,
the Greater the Chance the Rest of the
Jungle Will Hear.*

D) AAP Board approved funding to establish an AAP.org e-mail address for every AAP member. This is a wonderful branding program for membership. The moment a recipient joins the AAP, an AAP.org address is issued to her/him.

This update may be expanded upon in the June issue of *AAP News* so be sure to scan and read it. Keep the membership questions coming. I'll get answers.

— Pat Moffatt, M.D.

Children's Mental Health Task Force (CMHTF)

The MCAAP has voted to recommend that its members utilize the Pediatric Symptom Checklist (PSC) to screen for mental health problems in children age 4 to 16 at preventive health visits. This tool can be downloaded for free at <http://psc.partners.org>. The PSC tool is in the public domain and has been shown to be a sensitive and specific tool to identify dys-

function in this age group. It is recognized that the use of this tool will take additional time and that providing mental health services to those identified will be an ongoing problem. A negative PSC screening test does not justify additional reimbursement for your services at a preventive visit. A positive screening test, however, could justify additional charges if you spend additional time counseling and coordinating care. This can be billed using the modifier -25 for those plans that accept it. Alternatively, you can schedule the patient for a return visit to separately address the mental health dysfunction. Although some plans recommend using the 99215 code for additional reimbursement in lieu of the usual code for preventive services, this will decrease your rate of well-visit compliance when analyzed using CPT codes.

The CMHTF is in the process of setting up a pilot program for pediatric/child psychiatry networks. Pediatricians having problems accessing child psychiatrists or counselors for children are urged to e-mail Walter Harrison at wharrison@mcaap.org. You may also contact the Massachusetts Office of Patient Protection at (800) 436-7757.

— Walter Harrison, M.D.

Pneumococcal Conjugate Vaccine Shortage Is Over!

Pneumococcal conjugate vaccine (PCV7) production and supply is now sufficient to permit a return to the routine four-dose schedule for all infants and young children. The Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) are recommending that all health care providers identify those children for whom doses have been deferred and recall them to complete the series.

Background

On December 28, 2001, the Massachusetts Department of Public Health (MDPH) issued an advisory alerting providers that a “moderate” shortage of PCV7 existed in Massachusetts and asked all providers to 1) defer the fourth dose in children < 24 months of age and 2) defer doses in healthy children between 24 and 59 months of age until adequate vaccine supplies were available. In Massachusetts, the shortage never became severe enough to affect the infant schedule, except possibly in a few circumstances that we believe were addressed immediately.

Providers were asked to continue immunization of all children with medical conditions placing them at high risk for invasive pneumococcal disease. They were also requested to maintain lists of children whose doses were deferred for recall when the shortage was over. During this time period, at least three cases of invasive pneumococcal disease due to a vaccine-related strain have been identified in Massachusetts children whose fourth dose was deferred as a result of the vaccine shortage.

Prioritization of Groups for Catch-Up

Since providers may not be able to recall all children simultaneously due to logistical or vaccine supply issues, groups to be recalled should be prioritized in the following order:

- 1) Any infants <12 months of age with <3 doses or high-risk* children of any age with <4 doses. In Massachusetts, there should not be any underimmunized children in these categories due to the vaccine shortage. However, if they are identified in your practice, they should be prioritized first for recall.
- 2) Children <24 months of age with <4 doses. Children <24 months of age whose fourth dose was deferred should be recalled second.
- 3) Children 24 to 59 months of age with <4 doses. Older children whose fourth dose was deferred should be recalled third. Prioritization within this older age group, if needed, would be given to children who are 24 to 35 months, American Indian/Alaska Native and black children, and those who attend group child care centers.

Disease Reporting

It is very important that we identify any additional cases due to the vaccine shortage, as well as any changes in the epidemiology of *Streptococcus pneumoniae* and its serotypes following PCV7 introduction. We urge providers to report all cases of invasive pneumococcal disease following PCV7 promptly, so we can facilitate timely submission of the specimens for

serotyping. Cases should be reported to both your local board of health and the MDPH Division of Epidemiology and Immunization at (617) 983-6800 or (888) 658-2850.

Vaccine Ordering

During the vaccine shortage, providers in Massachusetts were asked to reduce their normal monthly vaccine orders by at least 25%. The MDPH now advises providers to return to their normal vaccine ordering patterns for PCV7 by increasing their next monthly vaccine order by 30% and adding the number of additional doses necessary to catch up underimmunized children in their practice per the guidelines above. We anticipate vaccine orders will need to be increased by 30% to 50% over the next few months until catch-up is complete. As always, providers are encouraged to order vaccine on a monthly basis and to maintain no more than a one- to two-month inventory at any given time.

References

CDC. Pneumococcal conjugate vaccine shortage resolved. *MMWR* 2003;52(19):446-7.
www.cdc.gov/mmwr/PDF/wk/mm5219.pdf

Powell KP. Recommendations for the administration of catch-up doses of pneumococcal conjugate vaccine. *AAP News* 05/02/03. www.aap.org/member/pcv0503.htm

* High-risk groups include children with sickle-cell disease, asplenia, HIV infection, chronic illness (including cardiac disease, pulmonary disease, and diabetes), CSF fluid leak, cochlear implant, or other immunocompromising conditions and treatments.

Minors' Access Cards Available in Massachusetts

This important new resource was developed by Physicians for Reproductive Choice and Health (PRCH), the Massachusetts Chapter of the American Academy of Pediatrics, the Abortion Access Project, and the American Civil Liberties Union of Massachusetts, with appreciation to the Massachusetts Medical Society. The laminated pamphlet is small enough to fit into your lab coat pocket for use during rounds and visits with patients. The card summarizes the complex laws surrounding the provision of health services to ado-

lescents in Massachusetts.

The card covers issues of confidentiality and consent when treating minors, specifically addressing contraceptive care and counseling, pregnancy tests and options counseling, abortion services, sexually transmitted infections, and treatment and substance abuse care.

Physicians for Reproductive Choice and Health is a national, physician-led, not-for-profit organization whose mission is to enable concerned physicians to take a more active and visible role in support of

universal reproductive health. PRCH is committed to ensuring that all people have the knowledge, equal access to quality services, and freedom of choice to make their own reproductive health care decisions.

Minors' Access Cards can be ordered by calling Crystal Sanford at (646) 366-1890, ext. 11, or by e-mailing crystal@prch.org. The cards can also be downloaded from www.prch.org.

MCAAP Formulary Guide: Tiers

BCBS HPHC GIC Neighborhood HP Network Health additional notes

Acne, topical

benzoyl peroxide (1)	benzoyl peroxide (1)	benzoyl peroxide (3)	benzoyl peroxide (1)	benzoyl peroxide (\$)
Cleocin-T (1)	Cleocin-T (1)	Cleocin-T (1)	Cleocin-T (1)	Cleocin-T (\$\$)
Benzaclin (3)	Benzaclin (2)	Benzaclin (2)	Benzaclin (3)	Benzaclin (\$\$\$)
tretinoin (1)	tretinoin (1)	tretinoin (1)	tretinoin (2)	Retin A (\$\$\$)
				Tazorac (\$\$\$)
				Differin (\$\$\$)

Acne, oral

doxycycline (1)	doxycycline (1)	doxycycline (1)	doxycycline (1)	doxycycline (\$)
minocycline (1)	minocycline (1)	minocycline (1)	minocycline (1)	minocycline (\$\$\$)
tetracycline (1)	tetracycline (1)	tetracycline (1)	tetracycline (1)	tetracycline (\$)

ADHD

methylphenidate (1)	methylphenidate (1)	methylphenidate (1)	methylphenidate (1)	methylphenidate (\$)
Ritalin SR (1)	Ritalin SR (1)	Ritalin SR (3)	Ritalin SR (2)	Ritalin SR (\$)
Adderall (1)	Adderall (1 or 2)	Adderall (1)*	Adderall (1)	Adderall (\$\$)
Strattera (NF)*	Strattera (3)	Strattera (2)	Strattera (NF)**	Strattera (3)**
Adderall XR (3)	Adderall XR (2)	Adderall XR (2)*	Adderall XR (2)	Adderall XR (\$\$)
Concerta (2)	Concerta (3)	Concerta (2)	Concerta (3)*	Concerta (\$\$)
Metadate CD (2)	Metadate CD (2)	Metadate CD (2)	Metadate CD (2)	Metadate CD (\$\$)
Ritalin LA (2)	Ritalin LA (NF)*	Ritalin LA (3)	Ritalin LA (2)	Ritalin LA (\$\$)

Allergy, eye (consider OTC Naphcon A, Opticon A, Visine A)

cromolyn (1)	cromolyn (1)	cromolyn (1)	cromolyn (1)	cromolyn (\$\$)
Patanol (2)	Patanol (2)	Patanol (2)	Patanol (2)	Patanol (\$\$\$)

Allergy, nasal (consider OTC cromolyn [Nasal crom] and nasal saline washes [e.g., Neti pots])

Astelin (2)	Astelin (2)	Astelin (2)	Astelin (2)	Astelin (\$\$\$)
Nasarel (1)	Flonase (2)*	Flonase (2)*	Flonase (2)*	beclomethasone/ Flonase/Nasarel
Flonase (2)	Nasonex (2)	Nasonex (2)	Nasonex (2)*	Nasonex/Nasacort AQ/ Rhinocort/
Nasonex (2)	Nasonex (2)	Beconase (2)	Rhinocort (2)	Rhinocort AQ/Tri-Nasal

Antibacterial, oral (cephalosporins 1st generation)

cephalexin (1)	cephalexin (1)	cephalexin (1)	cephalexin (1)	cephalexin (\$)
Duricef (1)	Duricef (3)	Duricef (1)	Duricef (2)	Duricef (\$\$)

MCAAP Formulary Guide: Tiers

additional notes

Network Health

Neighborhood HP

GIC

HPHC

BCBS

Antibacterial, oral (cephalosporins 2nd generation)

cefaclor (1)	cefaclor (1)	cefaclor (2)	cefaclor (1)	cefaclor (\$\$)
cefuroxime (1)	cefuroxime (1 or 2)	cefuroxime (2)	cefuroxime (2)	cefuroxime (\$\$\$\$)
Cefzil (2)	Cefzil (2)			
	Lorabid (3)			
	Vantin (3)			

Antibacterial, oral (cephalosporins 3rd generation)

Suprax (2)	Suprax (2)	Suprax (3)	Suprax (2)	Suprax (\$\$\$)
	Cedax (3)	Cedax (3)	Cedax (3)	Cedax (\$\$\$)

Antibacterial, oral (macrolides)

Zithromax (2)	Zithromax (2)	Zithromax (2)	Zithromax (2)	Zithromax (\$\$\$\$)
Biaxin (2)	Biaxin (3)	Biaxin (2)	Biaxin (3)	Biaxin (\$\$\$\$)
erythromycin (1)	erythromycin (1)	erythromycin (1)	erythromycin (1)	erythromycin (\$)

Antibacterial, oral (penicillins)

amoxicillin (1)	amoxicillin (1)	amoxicillin (1)	amoxicillin (1)	amoxicillin (\$)
Augmentin (1)	Augmentin (2)	Augmentin (2)	Augmentin (2)	Augmentin (\$\$\$)
Augmentin ES (2)	Augmentin ES (2)	Augmentin ES (2)	Augmentin ES (2)	Augmentin ES (\$\$\$)
Pen Vee K tabs (1)	Pen Vee K tabs (1)	Pen Vee K tabs (1)	Pen Vee K tabs (1)	Pen Vee K tabs (\$)

Antibacterial, eye

Ilotycin (1)	Ilotycin (1)	Ilotycin (1)	Ilotycin (1)	Ilotycin (\$)
Polytrim gtts (3)	Polytrim gtts (3)	Polytrim gtts (1)	Polytrim gtts (3)	Polytrim gtts (\$\$)
Sulamyd gtts (1)	Sulamyd gtts (1)	Sulamyd gtts (1)	Sulamyd gtts (3)	Sulamyd gtts (\$)
Ciloxan (2)	Ciloxan (2)	Ciloxan (2)	Ocuflox (2)	Ocuflox (\$\$\$\$)
			Ocuflox (2)	

Antibacterial, otic (*consider rubbing alcohol/vinegar for mild cases*)

Cortisporin (3)	Cortisporin (1)	Cortisporin (1)	Cortisporin (1)	Cortisporin (\$\$)
gentamicin (1)	gentamicin (1)	gentamicin (1)	gentamicin (1)	gentamicin (\$)
Cipro HC (2)	Cipro HC (2)		Floxin (2)	Floxin (\$\$\$\$)

Antidepressants

bupropion (1)	bupropion (1)	Prozac (1)*	bupropion (2)	bupropion (\$\$)	*preferred drug
Prozac (1)		Luvox (1)	Prozac (1)	Prozac (\$\$)	
Celexa (2)		Celexa (2)	Celexa (2)*	Celexa/Lexapro/	*prior authorization
Lexapro (2)		Lexapro (2)	Lexapro (2)*	Paxil/Paxil CR/	*prior authorization
		Paxil (2)	Paxil (2)*	Prozac Weekly/	*prior authorization
		Zoloft (2)	Zoloft (2)*	Zoloft (\$\$\$\$)	*prior authorization

MCAAP Formulary Guide: Tiers

BCBS	HPhC	GIC	Neighborhood HP	Network Health	additional notes
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Antifungal, oral

Diflucan (2)	Diflucan (2)	Diflucan (2)	Diflucan (2)*	Diflucan (\$\$\$\$\$)	*prior authorization
Lamisil (2)*	Sporanox (3)*	Sporanox (2)*	Sporanox (3)*	Sporanox (\$\$\$\$\$)	*prior authorization
Lamisil (2)*	Lamisil (2)*	Lamisil (2)*	Lamisil (2)*	Lamisil (\$\$\$\$\$)	*prior authorization

Antifungal, topical (consider OTC fungostatic clotrimazole [Lotrimin] or fungocidal terbinafine [Lamisil])

clotrimazole (1)	Loprox (2)				
ketoconazole (1)	ketoconazole (1)				

Antihistamine (non/low-sedating)

Allegra (2)	Zyrtec (2)	Zyrtec (3)	Zyrtec (3)*	Zyrtec (\$\$\$\$)	*prior authorization
	Allegra (2)	Allegra (2)	Allegra (3)*	Allegra (\$\$\$\$)*	*prior authorization
			Claritin (3)*	Claritin (\$)	*prior authorization

Antihistamine (sedating — consider OTC diphenhydramine [Benadryl])

Periactin (1)	Periactin (1)	Periactin (1)	Periactin (1)	Periactin (\$\$)	
Atarax (1)	Atarax (1)	Atarax (1)	Atarax (1)	Atarax (\$)	

Antiviral

acyclovir (1)	acyclovir (1)	acyclovir (1)	acyclovir (1)	acyclovir (\$\$)	
Famvir (2)	Famvir (3)	Famvir (3)	Famvir (3)	Famvir (\$\$\$)	
Valtrex (2)	Valtrex (2)	Valtrex (2)	Valtrex (2)	Valtrex (\$\$\$)	

Asthma therapy (bronchodilators, immediate relief)

albuterol (1)	albuterol (1)	albuterol (1)	albuterol (1)	albuterol (\$\$)	
Xopenex (2)	Xopenex (3)	Xopenex (2)	Xopenex (3)	Xopenex (\$\$\$\$\$)	

Asthma therapy (controller medications)

Flovent (2)	Flovent (2)	Flovent (2)	Flovent (2)	Flovent (\$\$)	
Singulair (2)	Singulair (2)	Singulair (2)	Singulair (2)	Singulair (\$\$\$\$)	
Serevent (2)	Serevent (2)	Serevent (2)	Serevent (2)	Serevent (\$\$\$\$)	
Accolate (2)	Accolate (3)	Accolate (2)	Accolate (3)	Accolate (\$\$\$\$)	
Advair (3)	Advair (2)	Advair (2)	Advair (2)	Advair (\$\$\$\$\$)	
Aerobid (2)	Foradil (2)	QVAR (2)			

Gastrointestinal (consider OTC cimetidine, famotidine, ranitidine [Tagamet, Pepcid, Zantac])

cimetidine (1)	cimetidine (1)	ranitidine (1)	ranitidine (1)	cimetidine (\$)	
ranitidine (2)	Prilosec (2)	Aciphex (1)	Aciphex (1)	ranitidine (\$)	
Nextium (2)	Nextium (2)	Prevacid (2)	Prevacid (2)	famotidine (\$\$)	
				Protonix (\$\$\$)	

MCAAP Formulary Guide: Tiers

BCBS HPHC GIC Neighborhood HP Network Health additional notes

Gastrointestinal, *continued*

Aciphex (3)
Protonix (3)

OCPs, monophasic

Necon 1/35, 1/50 (1)*	April (1)	Loestrin (2)*	*preferred drug
Zovia (1)*	Necon 1/35, 1/50 (2)	Nelova (2)	*preferred drug
Mononessa (1)*	Ortho Novum 1/35 (2)		*preferred drug
Sprintec (1)*	Ortho Novum 1/50 (2)		*preferred drug
Yasmin (1)	Yasmin (2)		
Cryselle (1)			
Microgestin (1)			

OCPs, triphasic

Trivora (1)*	Trivora (1)	Tri-Levlen (2)*	*preferred drug
Enpresse (1)	Tri-Levlen (2)	Tri-Norinyl (2)	
	OrthoNovum 7/7/7 (2)		

OCPs, progestin only

Camila (1)	Camila (1)	Nor-qd (2)	Norethindron (\$\$)
Errin (1)	Errin (1)		
	Micronor (2)		

OCPs, other

Ortho Evra patch (2)	Ortho Evra patch (3)	Ortho Evra patch (2)	Ortho Evra patch (3)	Ortho Evra patch (\$\$)
NuvaRing (3)	NuvaRing (3)	NuvaRing (2)	NuvaRing (NF)*	NuvaRing (\$\$\$)

*prior authorization

Steroids, oral

prednisolone (1)	prednisolone (1)	prednisolone (2)	prednisolone (1)	prednisolone (\$\$)
Orapred (3)	Orapred (1)	Orapred (2)	Orapred (2)	Orapred (\$\$)
Pediapred (3)	Pediapred (1)	Pediapred (2)	Pediapred (2)	Pediapred (\$\$)

Steroids, topical, medium potency (*always consider using generics rather than branded steroids*)

betameth valerate (1)*	hydrocort valerate (1)*	fluocinolone (1)*	betameth valerate (1)	*preferred drug
fluocinolone (1)	triamcinolone (1)	betameth dipropionate (1)		

Steroids, topical, high potency (*always consider using generics rather than branded steroids*)

desoxymetasone (1)*	betameth dipropionate (1)	fluocinolone (1)	betameth valerate (1)	*preferred drug
fluocinolone (1)				

MCAAP Formulary Guide: Drug Formulations and Dosing

Note: Please consult your own dosing reference and consider drug interactions and contraindications. Doses by weight may not indicate maximum dose.

Acne, topical

benzoyl peroxide 5/10% cream, gel, or lotion Apply qday-bid

clindamycin (Cleocin-T) gel, lotion,
or solution Apply qday-bid

benzoyl peroxide 5%/clinda (Benzacilin) gel Apply qday-bid

tretinoin (Retin-A) 0.025/0.05/0.1% cream
or 0.025/0.1% gel Apply qhs

Acne, oral

doxycycline 50/100 mg caps or 100 mg tabs 100 mg po bid

minocycline (Minocin) 50/100 mg caps
and tabs 50–100 mg po bid — less affected by dairy

tetracycline 250/500 mg caps and tabs 500 mg po bid-tid

ADHD

methylphenidate (Ritalin) 5/10/20 mg tabs Titrate to effect

methylphenidate (Ritalin SR) 20 mg tabs Titrate to effect

mixed amphetamine salts (Adderall)
5/10/20/30 mg tabs Titrate to effect

atomoxetine (Strattera) 10/18/25/40/60 mg
capsules 0.5 mg/kg qday for 4 doses then 1.2 mg/kg qday

Adderall XR 5/10/15/20/25/30 mg capsules Titrate to effect

Concerta 18/27/36/54 mg capsules Titrate to effect

Metadate CD 20 mg capsules Titrate to effect

Ritalin LA 20/30/40 mg capsules Titrate to effect

Allergy, eye

cromolyn 4% solution 1–2 gtts qid

olopatadine 0.1% solution (Patanol) 1–2 gtts bid

Allergy, nasal

azelastine (Astellin) 2 sprays per nostril bid

Most nasal steroid sprays 1 spray per nostril qam

Antibacterial, oral (cephalosporins 1st generation)

cefadroxil (Duricef) 125/250/500 per 5 susp
or 500 mg caps or 1 g tabs 15 mg/kg/dose bid

cephalexin (Keflex) 125/250 per 5 susp or
250/500 mg caps 10–12 mg/kg/dose tid-qid

Antibacterial, oral (cephalosporins 2nd generation)

cefactor (Ceclor) 125/187/250/375/500 per
5 susp or 250/500 mg caps 13 mg/kg/dose tid — has
unique serum sickness reaction

cefepodoxime (Vantin) 50/100 per 5 susp or
100/200 mg tabs 5 mg/kg/dose bid

cefprozil (Cefzil) 125/250 per 5 susp or
250/500 mg tabs 15 mg/kg/dose bid

cefuroxime (Cefim) 125/250 per 5 susp or
125/250/500 tabs 15 mg/kg/dose bid

loracarbef (Lorabid) 100/200 per 5 susp or
200/400 mg caps 15 mg/kg/dose bid

Antibacterial, oral (cephalosporins 3rd generation)

cefixime (Suprax) 100 per 5 susp or
200/400 mg tabs 8 mg/kg/dose qd — consider alternative
given inavailability

ceftibuten (Cedax) 90 mg per 5 susp or
400 mg tabs 9 mg/kg/dose qd

Antibacterial, oral (macrolides)

azithromycin (Zithromax) 100/200 per
5 susp or 250 mg cap 10 mg/kg on day 1, 5 mg/kg days 2 to 5 for OM,
12 mg/kg/day x 5 days for strep pharyngitis

clarithromycin (Biaxin) 125/250 per 5 susp
or 250/500 mg tabs 7.5 mg/kg/dose bid x 7 days — consider
alternative to suspension due to poor flavor

erythromycin 200/400 per 5 susp (EES) or
250/333/500 mg tabs (base) 10–15 mg/kg/dose tid — higher rate of GI upset

Antibacterial, oral (penicillins)

amoxicillin 250/500 per 5 susp or 250/500 mg caps	15-30 mg/kg/dose tid (max dose 4 g per day)
amoxicillin/clavulanate (Augmentin) 200/400 per 5 susp or 250/500 mg tabs	20 mg/kg/dose bid (not recommended for otitis)
amoxicillin/clavulanate (Augmentin ES) 600 per 5 susp	45 mg/kg/dose bid
Pen Vee K tablets 250/500 mg tabs	250 mg tid or 500 mg bid x 10 days for strep pharyngitis

Antibacterial, eye

erythromycin ointment	Apply to affected eye tid-qid x 5 days
Polytrim drops	1 gtt q4 hours x 7 to 10 days
sulfacetamide (Sulamyd) drops 10/15/30% solution	1-2 gtt q4 hours x 7 to 10 days
ciprofloxacin (Ciloxan) 0.3% solution	1-2 gtt q2 hours while awake x 2 days, then 1-2 gtt q4 hours while awake x 5 days
ofloxacin (Ocuflox) 0.3% solution	1-2 gtt q2 hours while awake x 2 days, then 1-2 gtt q4 hours while awake x 5 days

Antibacterial, otic

Cortisporin otic suspension	3-5 gtt in ear tid
gentamicin ophthalmic or otic drops	3-5 gtt in ear tid
Most fluoroquinolone drops	3-5 gtt in ear bid

Antidepressants (dosing for adult patients)

fluoxetine (Prozac) 20 per 5 solution or 10/20 mg caps	Start 20 mg qday; max dose 40 mg qday
citalopram (Celexa) 10/40 mg tabs	Start 20 mg qday; max dose 40 mg qday
fluvoxamine (Luvox) 25/50/100 mg tabs	Start 25 mg qhs, increase by 25 mg in bid dosing to max of 200 mg per day
escitalopram (Lexapro) 10/20 mg tabs	10 mg qday
paroxetine (Paxil) 10/20/30/40 mg tabs	20 mg qam; max dose 50 mg qday
sertraline (Zoloft) 25/50/100 mg tabs	Start 50 mg qday; max dose 200 mg qday
bupropion (Wellbutrin) 100/150 mg sustained release tabs	Start 150 mg qam; after one week, increase to 150 mg bid — rate of seizures 0.4%

Antifungal, oral

fluconazole (Diflucan) 10/40 per 5 susp or 50/100/150/200 mg tabs	10 mg/kg on day 1, then 5 mg/kg per day for oral/esophageal candidiasis or 150 mg po x1 for vaginal candidiasis
itraconazole (Sporanox) 10 per 5 liquid or 100 mg caps	200 mg bid x 1 week, repeat qmonth (2 months for fingernails, 3 to 4 months for toenails)
terbinafine (Lamisil) 250 mg tabs	500 mg qday x 1 week, repeat qmonth (2 months for fingernails, 4 months for toenails)

Antifungal, topical

ciclopirox (Loprox) 1% cream (fungocidal)	Apply bid x 7 to 14 days
clotrimazole (Lotrimin) 1% cream (fungostatic)	Apply bid x 3 to 4 weeks
ketoconazole (Nizoral) 2% cream (fungostatic)	Apply qday x 3 to 4 weeks

Antihistamine (non/low-sedating)

cetirizine (Zyrtec) 5 per 5 syrup or 5/10 mg tabs	2.5 mg ages 2 to 5, 5-10 mg ages 6 and over
fexofenadine (Allegra) 30/60/180 mg tabs	30 mg bid for ages 6 to 12, 60 mg bid or 180 mg qday for adults
loratadine (Claritin) 5 per 5 syrup or 10 mg tabs	5 mg ages 2 to 5, 10 mg ages 6 and over

Antihistamine

cycloheptadine (Periactin) 2 per 5 syrup or 4 mg tabs	4 mg tid, max 32 mg per day (adult dosing)
hydroxyzine (Atarax) 10 per 5 syrup, 25 per 5 susp, or 10/25/50/100 mg tabs	0.5-1 mg/kg/dose up to 100 mg per day divided qday-qid

Antiviral (herpes treatment/prophylaxis for adults)

acyclovir 200 per 5 susp, 200 mg caps, 400/800 mg tabs	400 mg tid x 7 to 10 days for 1st genital herpes, x 5 days for recurrent or 400 bid for suppression
famciclovir (Famvir) 125/250/500 mg tabs	250 mg tid x 7 to 10 days for 1st genital herpes, 125 bid x 5 days for recurrent or 250 bid for suppression
valacyclovir (Valtrex) 500/1000 mg tabs	1000 mg po bid x 10 days for 1st genital herpes, 500 bid x 5 days for recurrent or 500-1000 qd for suppression

Asthma therapy (bronchodilators, immediate relief)

albuterol MDI or 0.5% conc soln or 0.083% premixed soln 2 puffs or 1.25-2.5 mg nebulized q4 hours prn
 levalbuterol (Xopenex) 0.31/0.63/1.25 mg unit doses 0.31-1.25 mg nebulized q4 hours prn

Asthma therapy (controller medications)

fluticasone (Flovent) 44/110/220 mcg inhalers 2 puffs bid
 montelukast (Singulair) 4/5 mg chewable or 10 mg tab 1 tab po qhs
 salmeterol (Serevent) 2 puffs bid
 zafirlukast (Accolate) 20 mg tab 20 mg po bid
 fluticasone/salmeterol (Advair) 100/250/500 mcg discus 1 inhalation bid
 flutisolid (AeroBid) 2-4 puffs bid
 formoterol (Foradil) 1 inhalation bid
 beclomethasone HFA (QVAR) 40/80 mcg inhalers 1-2 puffs bid

Gastrointestinal

cimetidine (Tagamet) 300 per 5 syrup or 100/200/300/400/800 mg tabs 10 mg/kg/dose q6 hours — Adults: 800 mg per day divided qday-bid
 famotidine (Pepcid) 40 per 5 syrup or 10/20/40 mg tabs 0.4 mg/kg/dose q8 — Adults: 40 mg per day divided qday-bid
 ranitidine (Zantac) 75 per 5 syrup or 75/150/300 mg tabs 1.5 mg/kg/dose q8 — Adults: 300 mg per day divided qday-bid
 esomeprazole (Nexium) 20/40 mg caps 1 po qday
 lansoprazole (Prevacid) 15/30 mg caps 1 po qday
 omeprazole (Prilosec) 10/20/40 mg caps 1 po qday
 pantoprazole (Protonix) 20/40 mg tabs 40 mg bid
 rabeprazole (Aciphex) 20 mg tabs 1 po qday

OCPs

Most oral contraceptives 1 tab qday
 Ortho Evra patch Change patch weekly
 NuvaRing Insert ring in vagina monthly; remove after 21 days

Steroids, oral

prednisolone (15mg/5ml) 2 mg/kg x1, then 1 mg/kg/dose q12
 Orapred prednisolone (15mg/5ml) 2 mg/kg x1, then 1 mg/kg/dose q12
 Pediapred prednisolone (5mg/5ml) 2 mg/kg x1, then 1 mg/kg/dose q12

Steroids, topical (c = cream, l = lotion, o = ointment)

Medium-potency formulations
 betamethasone dipropionate (Diprosone) 0.05% (l) Apply sparingly qday-bid
 betamethasone valerate 0.1% (c) Apply sparingly qday-bid
 fluocinolone (Synalar) 0.025% (c, o) Apply sparingly bid-qid
 hydrocortasone valerate (Westcort) 0.2% (c, o) Apply sparingly bid-tid
 triamcinolone (Aristocort/Kenalog) 0.025/0.1/0.5% (c, o) Apply sparingly tid-qid

High-potency formulations

betamethasone dipropionate (Diprosone) 0.05% (c, o) Apply sparingly qday-bid
 betamethasone valerate 0.1% (o) Apply sparingly qday-bid
 desoxymetasone (Topicort) 0.25% (c, o) Apply sparingly bid
 fluocinolone (Synalar) 0.2% (c) Apply sparingly bid-qid

DEP Resumes, Expands Air Quality Forecasting

Reva Levin

On May 1, with the arrival of warmer weather and the traditional “smog season,” the Massachusetts Department of Environmental Protection (DEP) resumed daily air quality forecasting for ozone and announced that it will now be providing year-round daily forecasts for fine particles in the air.

The DEP issues its forecasts Sunday through Friday, with the Friday report including air quality predictions for the weekend. When concentrations of ozone or particles are elevated and expected to remain that way, the agency alerts the general public by updating the forecast on its toll-free Air Quality Hotline (800) 882-1497 and its website at www.mass.gov/dep, as well as by notifying the news media.

What Particles Are and Where They Come From

“Particles” or “particulate matter” are terms used to describe the mixture of solid particles and liquid droplets in the air we all breathe. Particles are a combination of fine solids (such as dirt, soil dust, pollens, molds, ashes, and soot) and liquid droplets that vary greatly in shape, size, and chemical composition. They are measured in microns (a micron is one millionth of a meter) and have been linked with a number of harmful health effects.

The DEP measures two types of particles in the ambient or outdoor air:

- ★ Coarse particles (between 2.5 and 10 microns in diameter). These come from a variety of sources, including natural wind erosion and airborne residue from some commercial and industrial operations. Individual particles cannot be seen with the naked eye, but collectively they can appear as haze, dust, or soot. (For comparison, a human hair is about 75 microns in diameter.)
- ★ Fine particles (up to 2.5 microns in diameter). These are generated by all types of fuel combustion, including power plants, cars, buses, trucks, and wood burning and by some industrial processes. Because of their minuscule size, fine particles can penetrate deeply into the lungs and accumulate in the respiratory system.

Health Problems Associated With Particle Pollution

Particles are present everywhere, but in

high concentrations, they can cause serious health problems. Scientific studies have linked particles with a number of significant health problems, including

- ★ Asthma, chronic bronchitis, and emphysema;
- ★ Acute respiratory symptoms, such as coughing and chest tightness; and
- ★ Decreased lung function, experienced as a shortness of breath.

These conditions contribute to work and school absences, emergency department visits, and hospital admissions.

Other Sources of Information

The U.S. Environmental Protection Agency (EPA) has developed an Air Quality Index (AQI) to be used nationally in ozone forecasting. More information about the AQI may be found at www.epa.gov/region01/oms/index.html.

More information on particles is available at www.epa.gov/ttn/oarpg/naaqsfm/pmhealth.html.

Long-term exposure can make existing conditions worse and even reduce life expectancy.

Because their lungs are still developing, children are considered a sensitive group when particle levels are high. In a recent study by the California Air Resources Board, in communities highly polluted with particles, children’s lungs developed more slowly and did not move air as efficiently as children’s lungs in clean air communities.

Children inhale more air per pound of body weight than do adults. They breathe faster, spend more time outdoors, and have smaller bodies. Their immature immune systems may cause them to be more susceptible to particles than are healthy adults.

Other sensitive groups include the elderly, particularly those with or prone to cardiovascular disease, and people with asthma or other existing respiratory ailments. Even healthy adults who exert themselves during periods of high particle concentrations may be affected as they breathe more heavily while working or exercising.

Particles can reduce outdoor visibility by as much as 70% from natural conditions when vast quantities of coarse and fine particles appear as haze, dust, or soot. Airborne particles and droplets also tend to remain suspended in the air for extended periods of time and travel long distances. When they eventually settle to the surface, they can soil or damage property, plants, and animals.

Difference Between Particles and Ozone

Particles and ozone, which the DEP has forecast for the last several years, are similar in many respects. (For more detailed information on ozone, see the summer 2002 issue of *The Forum*). Each of them can cause respiratory symptoms and other serious health problems among sensitive populations, and fossil fuel combustion is a leading source of both.

One significant difference between the two pollutants is that particles can be a problem at any time of year, unlike ozone, which forms in warm, sunny weather and therefore tends to be seasonal in nature. For this reason, the DEP issues forecasts of the expected concentrations of fine particles year-round, while ozone forecasts are issued from May 1 through September 30.

Air Quality Monitoring

The DEP has been monitoring ambient air quality with a network of monitors across the state since the 1960s. The primary goal of this network is to determine whether the air in the state meets national air quality standards designed to protect public health. The DEP started monitoring particles in 1999 and currently maintains particle monitors at 16 locations.

Most of these monitors collect air samples on filters that are analyzed in a laboratory with results usually available in a few days. A number of these locations also monitor particles on a continuous basis, providing hourly measurements. Currently, predictions of particle concentrations are limited to the cities of Boston, Worcester, and in the near future, Springfield. The DEP plans to expand its particle-monitoring network and allow for forecasting in other parts of the state in the near future.

For more information on DEP air quality forecasting, please call Reva Levin at (617) 556-1135.

President's Message

Continued from page 1

toxins in air, water, and the food chain than ever before; 5) Multivariate statistical analysis is much more commonly used; 6) There are more detailed long-term data for more people for more years; and 7) There are bigger, more meticulous studies looking specifically at a wide variety of factors than before. We are looking differently, more carefully, more broadly.

We are also accruing vastly more genetic information, and with it, researchers are beginning to investigate whether people with certain genetic configurations are more sensitive to, or respond differently to, chemical and biological agents. Fetuses with certain genomes are more affected than others by the cigarettes their mothers smoke, certain people get AIDS while others don't, and certain elders get specific cancers while others don't.

To gain an understanding of these conditions, we have to open our eyes to a vast array of factors that most of us have discounted in the past: levels of basic elements and micronutrients in our bodies and our diets; products such as insecticides, food additives, and preservatives; exposures to allergens and antigens in gestation and infancy; and industrial and home waste.

You and I actually have important roles to play, both passive and active. Resolve never again to scoff at people who posit that some previously accepted or highly illogical food, toxin, or factor might be harmful. The answer is not "You idiot, that's ridiculous"; it's "We have no evidence for that yet. We need lots of long-term data in order to study it."

We are frequently asked, and even required, to participate in gathering this data. Help out. For example, the state passed legislation last year that requires all physicians to report the presence of a wide array of both major and minor birth defects their patients have. The state has drawn up a list, including metabolic and anatomical conditions, which can be accessed by visiting www.state.ma.us/dph/bhsre/birthdefects/bdefects.htm.

This is not just a legal responsibility, it's a professional and medical one. The only way to identify these very subtle, often very long-term relationships between genetic, environmental, immunological, medical, behavioral, and cognitive factors is for all of us to first accept the likelihood that they exist and second support the broad, long-term studies that are required to discover the answers. Here is something we can do that will have real meaning over time. Please help.

— John G. (Sean) Palfrey, M.D., FAAP

Reactions to DTaP Vaccine Dose #5

Do you have patients in your practice that have had marked local reactions after the fourth DTaP? Is it nearing time for the fifth dose?

The Clinical Immunization Safety Assessment Centers (CISA), in association with the CDC, are doing a national study of reactions after the fifth DTaP in children who have had significant limb-swelling reactions after their fourth DTaP. Boston Medical Center is a study site under the direction of Dr. Colin Marchant in collaboration with Jerome Klein, M.D.; William Adams, M.D.; Elizabeth Barnett, M.D.; and Catherine Fleming, M.D.

Three Reasons This Research Study Is Being Done

1. To follow children after the fifth dose of DTaP to study reactions;
2. To give children one of two different DTaP vaccines for the fifth dose to see if there are differences in reactions after the different vaccines; and
3. To compare antibody levels in the blood of children who do and who do not have reactions after the fifth DTaP.

This study will determine the safety of DTaP immunizations in those with prior reactions.

If You Would Like to Refer Patients

The study team is currently available to

1. Meet the family at your practice or any convenient site and
2. Enroll patients, complete study procedures, and arrange and carry out follow-up visits. The study visits will consist of a vaccination/blood test visit, a follow-up visit, and two to three telephone calls.

To refer patients, please contact Susan Michalski, R.N., at (617) 414-7423 or by e-mail at spm@bumc.bu.edu

Information is available at our website: www.vaccinesafety.org

'PARI' Nebulizer Program

We supply the pediatric physician's office with nebulizers to be dispensed to patients in need. This program is easy for the physician and easy for the patient. Call for details and references.

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PROS Is Looking for You

Ben Scheindlin, M.D.

PROS (Pediatric Research in Office Settings) is the AAP's national practice-based research network. Comprised of over 1,700 practitioners from 614 practices in 59 AAP chapters, PROS practitioners collaborate on research studies addressing important child health topics. Massachusetts is the largest PROS Chapter with 33 practices and 143 practitioners.

We need you! These two exciting PROS studies, CARES and Safety Check, are actively recruiting practitioners now.

Child Abuse Recognition and Evaluation Study (CARES)

This descriptive study seeks to understand how pediatricians assess injuries, distinguish those resulting from abuse, and manage those injuries in the real world. It will provide the first comprehensive description and analysis of primary care providers' detection and management of suspected child abuse, an issue that confronts all practicing pediatricians on a regular basis. Participating practitioners

will complete pocket-sized encounter forms on 40 children with injuries. The study team follows up with some of the participating practitioners by phone one and six months later. This is a very easy study to do in the office — confidentiality of patient and doctor is assured — and the study is HIPAA compliant. Author of the Massachusetts Medical Society VIP booklets and PROS practitioner Bob Sege of the Floating Hospital is one of the principal investigators. MCAAP member David Norton of Ware is one of the PROS practitioner consultants who helped design and pilot test CARES, and he is presently helping to recruit practices for the study.

Safety Check: A Randomized Controlled Trial to Prevent Child Violence

This is the first interventional study in PROS. Using a souped-up questionnaire with linked educational materials, participating practices will be randomly assigned to an innovative violence prevention intervention arm or to a comparison arm with an unrelated anticipatory guidance inter-

vention, encouraging reading aloud. Each practitioner will only be asked to enroll 30 children aged 2 to 11 years coming in for check-ups. This study is easy to work into routine check-ups in your office. Summer and fall are ideal seasons to do this health maintenance-oriented study. MCAAP member Ben Scheindlin of Burlington is one of the PROS practitioner consultants who helped design and pilot test Safety Check.

Any interest? Call for more information:
David Norton (413) 967-2040
Ben Scheindlin (781) 272-2210
Hank Bernstein (617) 355-7960



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My “Critical Incident” as a Third-Year Student

I'll never forget my encounter with her at the hospital. Mrs. _____ was a 78-year-old lady with a history of chronic renal failure and bipolar disorder admitted to the hospital for dialysis consideration. Her renal failure had progressed to end-stage. She was going to die if she was not put on dialysis soon. I remember looking at her chart, unsure of whether I was going to deal more with the renal failure issue or with her bipolar disorder. I walked into the room and saw a well-groomed, silver-haired woman who was well-composed and was slowly nibbling away at some food on her lunch tray. She greeted me pleasantly, and I introduced myself as a medical student. We began to chat away about her illness, her family, and her most recent hobbies.

The more time I spent with her, the more she reminded me of my late grandmother. Some of her mannerisms and gestures were remarkably similar to those of my grandmother when she was still alive. I became more comfortable with and eventually very close to Mrs. _____. Her bipolar disorder turned out to be a non-issue.

On the second day of our encounter, I decided to bring up the issue of dialysis with her. I explained to her that in end-stage renal failure, dialysis acts as a “filter” for her blood and expels the toxins and metabolites from her blood. She looked at me and smirked, “B_____ I know what dialysis is.” So I asked her when she would like to start and if her family would be willing to help her out. She replied, “I’m not getting dialysis.” I was confused for a moment. Then I suddenly realized what she was indirectly trying to tell me. I

explained to her that she was going to die if she refused dialysis. Initially I thought that she did not understand the procedure, but the more we talked, the more I realized that she was old, tired, and wanted what she called “closure.” I felt absolutely helpless. This woman has a chance to live through a chronic, not fatal, disease and yet she’s refusing to choose life. I just could not understand it.

Several years ago, my grandmother died at around the same age as Mrs. _____. I was very close to her because she lived with us. She had multiple eye conditions and could not walk or see very well. My brother and I would always care for her wherever she went. When she died in Taiwan, I was neither able to see her last waking moments nor attend her funeral. Mrs. _____, choosing not to receive dialysis, was going to die right in front of my eyes.

I was sitting at her bedside when we had this discussion, and out of nowhere, tears started gushing up to my eyes. She asked me why I was crying, and I told her that she reminded me of my grandmother. She replied, “So I guess I’m like your second grandmother.” I cried some more.

In her mind, Mrs. _____ could sense that I was not willing to let her go. She told me, “You’re still young, B_____, you’ll get used to situations like this.” But I did not want to admit to that, somewhere down the path of my career, I may become “hardened.” Not because I won’t care anymore, but because I will have built a hardened-shell around me to protect myself.

In retrospect, I realized that this was her decision to make. I knew it all along, but I just didn’t want to let her go. As long as she’s competent, the choice, of living a life hooked up to machines for hours on end for up to 4 or 5 days a week or simply telling herself that she’s lived a full life and has been satisfied with her accomplishments, was hers. I realized that as physicians, all we can do is make clear to patients the pros and cons of treatments and let them make informed decisions. The ultimate will and choice to live rests with the patient and the patient only. What we want for the patient is irrelevant, no matter how much we care.

I realized something else. When my grandmother died, my mother flew to Taiwan to be with her at her deathbed and later attended her mother’s funeral. She called frequently during that time, lamenting over the phone and seeking reassurance from us. We all tried our best to be strong for her, to say words of comfort and ease her sorrow. During this process, I don’t think I ever appropriately grieved over my grandmother’s death. Mrs. _____’s inevitable death probably provided the first outlet for my bereavement since my grandmother’s death several years ago.

No one ever found out about these conversations we shared. I did not tell any of my colleagues. I thought that it would be locked up in a special place inside me forever, but I share it today with all of you.

This article was submitted by a medical student at Boston University School of Medicine, Class of 2004.

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EDITOR: David Chung, M.D.

COPY EDITOR: Jennifer Carlisle

DESIGNER: Lisa Salvo

Massachusetts Chapter
American Academy of Pediatrics
P.O. Box 9132
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