A Note from the Chair
by Michele Moss, MD

This Holiday issue of the newsletter gets to start with good news. The AMA CPT Editorial Board approved the proposed global critical care code for children under 2 years old at their meeting in San Diego on November 10th. This code will be part of a package of global codes which include the neonatal code (initial and followup). There is an initial code for day of admission and a followup code for subsequent care. These codes will be included in CPT 2003. Our heartfelt thanks go to Dr. David Jaimovich who has spearheaded this endeavor. I can attest that David has put time and energy as well as heart and soul into this effort. Also I must thank Dr. Richard Molteni, Dr. Joel Bradley and the AAP Committee on Coding and Reimbursement (COCR). Dr. Molteni is a neonatologist who has been a leader in pediatric coding especially with the neonatal codes. He has served on the AMA CPT Editorial Board and his expertise and support to us in this effort has been priceless. The Academy’s COCR is a fairly young committee in the AAP but has shown great organization and leadership in working to get pediatric codes passed through the Editorial Board. I also want to thank Linda Walsh, the AAP staff person, who works with the COCR. She has been of tremendous help in keeping up communication on this issue. Thanks to all from the whole Section on Critical Care Executive Committee!

The next step in the process is the assignment of the relative value units (RVUs) by the Relative Value Update Committee (RUC). Several pediatric intensivists will be involved with helping determine the work associated with this code. That information will then be presented to the RUC and an RVU determined. Many of you may be asked for your help in this next step. Keep an eye on the newsletter in the spring for the outcome of that determination.

Despite concerns with travel this fall, there was a very good turnout for the Section on Critical Care Educational and Scientific Session in October. Dr. Tex Kissoon put together a very good program and the quality of abstracts was much improved this year. For those of you who missed it, the abstracts were printed in Pediatric Critical Care Medicine, which proved to be a very appropriate location for these abstracts. Thanks to Pat Kochanek, the editor of Pediatric Critical Care Medicine, in working with us to make that happen. The joint session with the Provisional Section on Neurosurgery on pediatric head injury was very informative and at times quite lively. It is always challenging and educational to mix the pediatric critical care medicine perspective with a surgical one.

The Executive Committee had a long and productive meeting during the National Conference and Exhibition in San Francisco. The workforce survey is essentially ready for distribution. We are in the process of determining how to distribute it and manage the data. This appears to be more costly than anticipated so we are working on how best to distribute the survey. Our educational goals are taking shape. The coding workshop under the leadership of Dr. Alice Ackerman is really taking shape. The preliminary slides are put together and ready for editing. No doubt it will be

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According to CPT 2001, a critical illness or injury “acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition.” “Critical care involves high complexity decision making to assess, manipulate, and support vital system function to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient’s condition.” Many of our patients in the pediatric intensive care unit no longer fit the CPT definition of critical care yet still require the monitoring and nursing resources in the PICU.

When a patient no longer meets the definition of critical care or the critical care time spent is less than 30 minutes, then the subsequent hospital care codes, 99231-99233, should be used. The three codes vary in complexity from the most simple, 99231, to most complex, 99233, with 99232 being the most common. The least complex code, 99231, requires performance and documentation of two of the following three components: problem focused interval history, problem focused examination, or medical decision making that is straightforward or of low complexity. The estimated time component is about 15 minutes at the patient’s bedside. The next code, 99232, requires an expanded problem focused interval history, expanded problem focused examination, or medical decision making of moderate complexity. The most complex code, 99233, requires a detailed interval history, detailed examination, or medical decision making of high complexity.

When developing a superbill for your PICU, it is important to remember that all the E&M codes that can possibly be used in your unit appear on that superbill. Also all levels of any given code should be listed to include the least complex up to the most complex. So in addition to the critical care codes, 99291 and 99292, and the neonatal ICU codes for infants <30 days, 99295, 99296 and 99297, the subsequent hospital care codes should also be listed. Other codes that should be added to the superbill include the initial hospital care codes, 99221 – 99223, for new admissions to the PICU who do not qualify for the critical care codes. Many superbills for PICUs also include observation codes (99217-99220) and hospital discharge codes (99238 and 99239).

Michele Moss
I. New and Relatively New Drugs:

1. Nesiritide: recombinant form of brain natriuretic peptide (BNP). Endogenous BNP is produced by left ventricular myocytes to counter-regulate the renin-angiotensin-aldosterone system (RAAS). Recombinant BNP promotes systemic and pulmonary vasodilatation without reflex tachycardia. It also induces natriuresis and diuresis while inhibiting the RAAS. Actions are based on the stimulation of cGMP. Studies looking at single bolus doses of 0.3, 1, 3, 10, 15 and 20 mcg/kg showed peak hemodynamic effect in 15 minutes with effects lasting up to 4 hours. Metabolism is via internalization by the natriuretic clearance receptor and hydrolysis by neutral endopeptidases on the vascular luminal surface. Metabolism and clearance are not affected by hepatic or renal insufficiency. Several large RCT’s in adults with congestive heart failure demonstrated clear improvement in cardiac index and clinical symptoms (fatigue, dyspnea, etc.). The most common side effect noted was hypotension.

2. Bosentan: endothelin receptor antagonist. Endothelin is the most potent vasoactive peptide producing constriction of coronary and renal artery constriction. In myocardial infarction, pulmonary hypertension and heart failure, levels of endothelin in tissue and plasma are increased. ET-1 is the major form of endothelin generated by humans. ET-1 increases contractile potency of norepinephrine, serotonin and AT-1; and sensitizes blood vessels to norepinephrine. There are two types of endothelin receptors, ET_\text{A} (main receptor in the heart, mediates vasoconstriction) and ET_\text{B} (in brain, lungs, kidneys, responsible for ET-dependent vasodilatation through release of PGI_\text{A}). Bosentan is a competitive non-peptide endothelin receptor antagonist that blocks both ET_\text{A} and ET_\text{B}. It acts as a vasodilator and neurohormonal blocker that improves LV function, and attenuates cardiac remodeling. It is available in both IV and oral forms. It is highly-protein bound, and is excreted primarily by biliary clearance. Studies in adults with congestive heart failure show improved cardiac index and reduced SVR and PVR. The REACH-1 multicenter trial of bosentan in adults demonstrated significant clinical improvement, but the trial was stopped because of moderate dose-related increase in liver enzymes (which resolved when drug was discontinued).

II. Drug Shortages: IV diphenhydramine

III. Medication Errors and Hazard Alerts:

1. Do not provide hypodermic syringes to parents for administering oral liquid medications to children. A parent assumed that the cap at the end of a hypodermic syringe was part of the whole syringe. He aspirated an antibiotic suspension without removing the cap, and when he squirted the drug into the child’s mouth, the cap came off and lodged in the child’s trachea. The child died from severe hypoxic-ischemic brain injury.

2. Refrain from referring to patients by “room or bed numbers.” In addition to being dehumanizing, this practice has been reported as a cause for medication administration errors as patients are moved from one bed or one room to another.

3. Duragesic (fentanyl) patches – when discharging patients with these patches, provide instructions for use. A woman applied the patches to all the areas on her body which were hurting, and was found unresponsive and hypoventilating from the narcotic overdose.

4. Naloxone (0.4 mg/mL), heparin (5,000 units/mL) and phenytoin (100 mg/2mL) carpujects all look alike.

5. MRI’s and metal objects: A 6 year old died from skull fractures and massive intracranial hemorrhage after he was hit by an oxygen tank pulled into the MRI magnet at high speed. Common metal objects brought into MRI rooms include IV poles, sandbags containing metal filling, defibrillators, and wheelchairs. A letter to the NEJM (2001; 345:1000-1) suggested the placement of highly sensitive walkthrough metal detectors ($2,500-$5,000) in the entrance of all MRI suites. Sounds like a great, inexpensive, and potentially life-saving suggestion.

6. Concomitant use of heparin and enoxaparin: with the increasing use of enoxaparin, practitioners should take precautions to avoid using both drugs in patients. Massive intracranial hemorrhage or hemorrhagic shock and death have been reported from the concomitant use of both drugs.

7. Sound-alike, look-alike names: Lamictal (lamotrigine), an antiepileptic drug has been confused with Lamisil (terbinafine), which is a topical antifungal. Lamictal has a new package insert which clearly points out the difference.

8. Nimbes (cisatracurium besylate): Two single-use preparations – one contains 20 mg/10 mL, and the other contains 200 mg/20 mL. They are packaged in cartons that look very similar. There are reports of prolonged paralysis in patients from overdoses that occurred when the preparation with higher concentration was mistaken for that with the lower concentration.

A light moment:
Four people were arrested after breaking into a veterinarian’s office. They broke in to steal Oxycodone (oxycodone, controlled release). Instead, they oxydentially stole oxytocin. Were these guys oxymorons? (Institute for Safe Medication Practices, ISMP, October 17, 2001, volume 6, issue 21).
I want to thank the Critical Care Section and the American Academy of Pediatrics for this award. Honestly, it is very nice — actually, much more than very nice. This is a most meaningful academic achievement and I truly appreciate it.

One of the very nice things about an award such as this is that it allows me to say thank you in a very public way. Families don’t get thanked enough and certainly they rarely get acknowledged publicly. I want especially to thank my wife Mona. There are a lot of nights and weekends spent on these projects and my family has put up with this as generously as any. Time extends innocently from a night to a week to a month to a year, and so on. Obviously, my family has taken the brunt of this, and it is very nice to be able to publicly say thank you - Mona.

This is also a time to thank and remember Urs Ruttimann, my research colleague for almost 20 years. Urs died several years ago. Most of you never met Urs. He was a biomedical engineer with an expertise in dynamic modeling, especially image modeling. And, he was a very good mathematician, so when he didn’t understand the statistics, he would learn it very fast. We were some of the first medical investigators to do relatively sophisticated regression analysis. Because he was an engineer and not a statistician, he was very attuned to the dynamic state of nature, and how analyses needed to truly model nature. Early on, we were able to use sophisticated analyses because he had an account at NIH, which had an excellent software package. For reasons too contorted to explain now, we needed to enter data into the NIH software via the hospitals first PC, an apple 2C and a 9K-baud modem. Back then, a 300 patient study was huge, and I can only begin to remember why - 300 data points/patient and 2-5 seconds per keystroke… But I did learn from this that there is no substitute for knowing your data. Although my mind did not work as fast as a computer, it did keep up with a 9K modem. Since then, I have always tried to do a substantial part of all the research assistant tasks, because that is crucial to understanding the strengths and limitations of the data. We all benefited from Urs, and we all have been a little cheated by his early death.

I remember well a Society of Critical Care Medicine meeting in the early 80’s when I presented some very early work with severity scoring, something as I recall I did with Tim Yeh. Jack Downs, who I hope most of you will know as a former winner of this award, and one of the originators of pediatric critical care, reviewed it. That year, they tried assigning a senior person to make some poignant comments. Jack got up after my 10 minutes, and said something like, “great stuff, but I am not sure what it really is and where it is going.” I think I really did know at least the direction this was going to go in. After multiple versions of severity of illness scores, I have been privileged to investigate some of the factors that are associated with quality of care, provide methodology for severity adjustment, and develop a quantitative quality assessment process for individual PICUs. Looking back it is really quite amazing where we have come from.

I’ve tried to think what a distinguished career really is and why I have been so honored. I know some of the things distinguished don’t mean: It doesn’t mean best since there are many with better careers. Certainly many have written better papers, and have made more important contributions.

So what is distinguishing? I believe that there are at least 3 distinguishing things and in every case, the pediatric critical care community is integral to all of them. The most distinguishing feature is that I have been privileged to collaborate with so many PICUs. From the first 9 PICUs who contributed data without any financial support to the 50 or so units now participating in Pediatric Intensive Care Unit Evaluations, pediatric ICUs and their directors and staff have been very willing to embrace multi-site studies. Even randomly selected units have been willing to participate. Of the 16 PICUs initially randomly selected in one study, all but one agreed to participate. And most signed up with excitement and enthusiasm. Many sites over the years have contributed data without cost.

Many have actually paid me! So the first distinguishing thing is that I have been very fortunate to have the best and most cooperative group of PICUs around.

The second distinguishing thing about my career is the number of people I have worked with. To be honest, I haven’t counted them up, but about 10 years ago, I had been privileged to have over 100 different co-authors. And that didn’t include acknowledgements. I have learned much from many of my co-authors. They have given of their time and dedication, often only to be mentioned in the middle of an author list. So the second distinguishing thing is that I have been very fortunate to have a very dedicated and most cooperative group of pediatric intensivists as co-authors and collaborators.

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Third, I have benefited greatly by the pediatric intensive care community’s acceptance of quantitative quality assessment. PICUs and the individuals who work in them have accepted that there are indicators of quality. They have collaborated, cooperated, donated, and participated in so many ways. But the most important thing is that pediatric ICUs want to provide the best care possible, and thus, they do the things necessary for self-assessments. They were willing to hear the bad news as well as the good news. And, they were willing to change if someone gave them a good reason to change. I was fortunate to be able to give them a good reason in terms of severity adjusted mortality, but they were the ones who changed. I am tremendously proud that I have been part of this process. I know that many many lives have been saved by the efforts to improve quality. I have seen the standarized mortality ratios before and after improvements were implemented. I have been able to measure these improvements that only come from saving lives. So the third distinguishing characteristic is the openness of Pediatric Critical Care to self-evaluation and self-improvement.

I have been fortunate to have participated in evaluations of what quality factors are associated with a good pediatric ICU. I also learned that quality factors do not substitute for an analysis of individual PICUs. So, I tried to find a way of evaluating individual PICUs. I hope this award means at least a tacit acceptance by many of the Pediatric Intensive Care Unit Evaluations (PICUEs) program. As I hope you know, this is a quantitative quality and efficiency assessment program, now in its third version of software, that has generated many manuscripts, several updates of the PRISM III score, many quality assessments, and some controversial discussion based on the premise that our prediction algorithms and some methods are patented and site licensed. I created PICUEs because I realized that pediatric critical care was advancing sufficiently rapidly that the algorithms get out of date rapidly. The important point is this: contemporary algorithms are required for quality assessments to have the credibility to influence care improvement processes in PICUs.

Once again, this is really a very significant honor for me.

Thank you very much.
Dr. Murray Pollack

Happy Holidays!
Michele Moss

A concerted effort by the Academy led to adoption of the codes, which will significantly improve reporting of services for pediatric critical care when they take effect Jan. 1, 2003.

CPT codes 99291 and 99292 currently are used for critical care of infants and toddlers. These are hourly, non-age-specific critical care evaluation and management codes that describe the initial hour (99291) or subsequent half-hour(s) (99292) of continuous bedside care to critically ill patients.

Notably, the current codes cannot be reported for most discussions with families or guardians. In addition, they are poorly suited to document frequent repeated physical examinations throughout a day, an approach that prevails in pediatrics. The relative value units (RVUs) associated with these codes are not reflective of the work and practice expense involved in caring for critically ill infants, since they have been based largely on adult data. And, presently, no mechanism exists to adjust the RVUs for the increased technical difficulty of caring for critically ill small children.

The poor fit of the hourly critical care codes with pediatric intensive care unit (PICU) practice has led to inadequate reimbursement for pediatric critical care. PICUs tend to be small; usually averaging eight beds each. The small numbers of patients coupled with relatively low reimbursement per patient have limited the resources available for such care. PICUs often are not self-sustaining, and their functioning depends on the goodwill of hospital administrations, which face their own scarcity of resources.

In 1999, a group of pediatric intensivists in the AAP Section on Critical Care determined that the only solution was a new CPT code. Section member David Jaimovich, MD, FAAP, a member of the Society of Critical Care Medicine, spearheaded the effort. Dr. Jaimovich drafted a new global daily code using the model of global neonatal evaluation and management codes (99295-99298). Several procedures were bundled into it, with the intention of developing a code that would account for a greater number of RVUs.

Dr. Jaimovich received significant support from the Section on Critical Care and the AAP Committee on Coding and Reimbursement, with particular assistance from Richard A. Molteni, MD, FAAP. Dr. Molteni, a consultant to the AAP Committee on Coding and Reimbursement and a member of the AAP Section on Perinatology, is a former CPT Editorial Panel member. His work on the pediatric critical care codes paralleled his successful efforts to revise the neonatal codes.

In February 2001, Charles J.A. Schulte III, MD, FAAP, chair of the Committee on Coding and Reimbursement and the Academy’s CPT adviser at the time, presented the proposed code to the CPT Editorial Panel.

Despite general support for the code, the CPT Editorial Panel tabled the proposal. Feedback from reviewing members revealed concerns about proliferation in global codes. The members incorrectly believed that most PICU patients were post-operative, and they were concerned that a global evaluation and management code might reduce reimbursement for global surgical codes. They also expressed doubt that repeated examinations interspersed with services to other patients constitute critical care.

Drs. Jaimovich and Molteni incorporated the panel’s feedback into a second version of their proposal, which was presented to the CPT Editorial Panel on Nov. 10, 2001. The updated proposal took a further step toward the neonatal model by developing initial and subsequent day pediatric critical care codes. The comparison became stronger since the Section on Perinatal Pediatrics sought to compress the two subsequent day critically ill neonatal codes into one, removing any reference to “stable” or “unstable” patients. During their presentation, Drs. Jaimovich and Molteni emphasized that standardization was among the Academy’s primary goals. Additionally, they provided data on the demographics of PICU patients to support their proposal and assuage the panel’s potential concerns.

The Academy’s efforts paid off. The panel approved the entire range of neonatal and pediatric critical care codes. The pediatric critical care codes will become effective on Jan. 1, 2003, after they are published in CPT 2003. Members should not use the codes until that time.

The next step is to present RVU recommendations for the codes to the AMA/Specialty Society Relative Value Scale Update Committee (RUC). In early February, the RUC will review Academy survey data and will recommend RVUs for the codes to the Centers for Medicare and Medicaid Services for possible inclusion on the 2003 RBRVS Medicare physician fee schedule.

Dr. Timmons is a member of the AAP Section on Critical Care Executive Committee.

NEW CPT CODES FOR PEDIATRIC CRITICAL CARE
Otwell Timmons, MD, FAAP
Pediatric critical care medicine has enjoyed many advances over the past two decades. Revolutionary changes in technology and life supporting measures have added greatly to our ability to care for patients and all of this has been complimented by advances in drug therapy. New drugs have been developed and released and our understanding of the important pharmacokinetic - pharmacodynamic (PK-PD) correlates of established drugs continue to increase. However the importance of these advances continue to be severely overshadowed by the lack of age appropriate dose recommendations which complicates the optimal use of nearly all of the medications used within the PICU.

For decades pediatric practitioners have had to rely upon incomplete clinical pharmacology information to guide their drug dosing for critically ill neonates, infants and children. This dearth of necessary drug dosing information has resulted in unfortunate therapeutic misadventures, fostered the overuse of medications, either as single agents or as unnecessary combinations of drugs when single agents would provide superior and safer therapy. Furthermore, this lack of information has frequently restricted the use of newer agents representing major advances in specific areas depriving children from receiving the benefits of such advances. In summary, the pediatric patient is at just as much risk of inadequate therapeutic response from improper dosing as the risk of adverse drug reaction/toxicity.

In 1992 a very important initiative reflecting the long, hard efforts of a nucleus of visionary pediatric pharmacologists came to fruition in the establishment of the National Institute’s of Health (NIH) Pediatric Pharmacology Research Unit (PPRU) Network within the National Institutes of Child Health and Human Development (NICHD). This program, the first of its kind in the NICHD, was to assemble a group of established programs of excellence in pediatric clinical trials directed toward the labeling of drugs which are already FDA approved as well as newer agents yet to be available in the United States. The initial network was comprised of 5 Centers including: Louisiana State University Medical Center, Shreveport, LA, Ohio State University/Columbus Children’s Hospital, Columbus, OH, University of California at San Diego/San Diego Children’s Hospital, San Diego, CA, University of Tennessee/LeBonheur Children’s Hospital, Memphis, TN and Wayne State University/Children’s Hospital of Michigan, Detroit, MI. Early in 1994 the network was expanded to include the University of Arkansas/Arkansas Children’s Hospital, Little Rock, AR and Case Western Reserve University/Rainbow Babies and Children’s Hospital, Cleveland, OH and in 1995, a site transfer occurred with the establishment of a network site at the Children’s Mercy Hospital in Kansas City, MO. Lastly, the competitive renewal process expanded the Network once more to a total of 13 sites, including the programs located at Baylor College of Medicine/Texas Children’s Hospital, Houston, TX, University of Cincinnati/Children’s Hospital Medical Center, Cincinnati, OH, The Children’s Hospital of Philadelphia, Philadelphia, PA, National Jewish Medical Center/The Children’s Hospital, Denver, CO and Yale University School of Medicine, New Haven, CT.

PPRU network activities focus on designing, implementing and executing the necessary studies that define optimal, age-appropriate dose recommendations for medications used in infants and children. The final goal of these studies is to result in proper labeling of the medication by the FDA for the pediatric patient. Studies may be either network studies (involving more than one PPRU site) or local initiatives, i.e., protocols conducted at only one PPRU site. PPRU sites welcome collaboration from all interested parties from within or outside of their host institutions. The lack of pediatric dosing data for the majority of drugs used in PICU practice underscores the importance of getting involved and helping to erase this severe limitation to the provision of optimal PICU care. Contact the PPRU Network center closest to you and get involved!

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Announcing the availability of the

AAP CALL FOR ABSTRACTS

for the

AAP National Conference and Exhibition
October 18 – 23, 2002
Boston, Massachusetts

Submission deadline:
April 15, 2001 for paper submissions
April 19, 2001 for electronic submissions
(Abstracts must be received by the dates listed.)

Section programs provide a forum for the discussion of clinical matters or research related to a particular subspecialty or special interest area. Submissions by AAP members and nonmembers are welcome; participation is open to health professionals in any field. (However, some sections require a sponsor for any papers whose authors do not include a member of the Section.)

The following Sections accept abstracts for presentation at the AAP National Conference and Exhibition. Abstracts are not accepted for general pediatrics or for other pediatric subspecialties or special interest areas not listed below.

Administration & Practice Management  Orthopaedics
Adoption                                 Perinatal Pediatrics
Breastfeeding                             Plastic Surgery
Cardiology                                School Health
Computers/Other Technologies             Sports Medicine and Fitness
Critical Care                             Surgery
Emergency Medicine                       Transport Medicine
Epidemiology                              Urology
Injury and Poison Prevention

Submit electronically from the AAP website
http://www.aap.org under “Professional Education”
(submission form will be available in mid-January)

Print versions can be obtained by calling the AAP Faxback Service at 847-758-0391.
Ask for Document 1201 (Abstract Form and Instructions) or Document 1202 (Section on Surgery Abstract Form and Instructions)

Questions? Contact abstracts@aap.org, or Rebecca Marshall at 847-434-4079.
Cardiopulmonary bypass (CPB) is known to cause fluid retention and, in some cases, peripheral vasoconstriction, which may lead to unfavorable hemodynamics and prolonged technology dependence in the postoperative period. These sequellae may be attributed to the increased secretion of vasopressin observed during CPB. Levels of vasopressin remain greater than physiologic for at least 24 hours after bypass. Given the normal actions of this hormone, antagonism of vasopressin may prove beneficial following CPB. We hypothesize that administration of a parenteral combined V$_1$ and V$_2$ receptor antagonist, conivaptan hydrochloride, will reduce fluid retention by enhancing free water excretion in the post-bypass period, without significant electrolyte derangement as occurs with loop diuretics. We further hypothesize that conivaptan hydrochloride will impart favorable hemodynamic effects by counteracting post-bypass vasoconstriction via vascular (V$_1$) receptor antagonism. We will test these hypotheses in sixteen mongrel dogs subjected to hypothermic nonpulsatile CPB (venoarterial ECMO). Urine output and hemodynamic parameters (heart rate, arterial blood pressure, pulmonary capillary wedge pressure, cardiac output, and calculated stroke volume and systemic vascular resistance) will be measured pre- and post- bypass and treatment, using indocyanine green, antipyrine, and insulin to measure plasma volume, total body water, and extracellular fluid, respectively. Serum and urine electrolytes will be serially measured to assess effects of therapy, if any. Finally, the contribution of conivaptan to these experimental outcomes will be assessed by evaluating the pharmacodynamics and pharmacokinetics of the drug in application of this agent to a number of similar problems encountered in the pediatric intensive care unit, including fluid overload and vasoconstriction related to extracorporeal life support for repair of congenital heart defects or for cardiovascular or respiratory failure, as well as fluid overload due to any cause.
The second PCCM match was held on November 7, 2001.

The following are the statistics:

**Programs:**

- Enrolled programs: 47
- Withdrew: 1
- Returned Rank order list: 47
- Active positions: 83 (Positions in the match)
- Programs Filled: 43% (20 programs)
- Programs NOT filled: 57% (26 programs)
- Positions filled: 63% (52 positions)
- Positions NOT filled: 37% (31 positions)

**Applicants:**

- Enrolled: 76
- Withdrew: 14
- Did not return rank order list: 5
- Active applicants: 57
- Matched applicants: 91% (52 applicants)
- Unmatched applicants: 9% (5 applicants)

**Rank/Match Preference**

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As can be seen by the numbers, the goal of making this process better for the applicant has been met as 67% of applicants matched with their first choice institution and 77% matched with their first two choices. There is a risk for the programs since only 33% of positions filled were by first choice, but 54% were filled by first two choices.

For the advantage of applicants the match should still continue, however, the fate of the match lies with the program directors.

Stephanie Storgion, MD
<table>
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<tr>
<th>Meeting Title</th>
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<tr>
<td>SCCM Scientific Symposium</td>
<td>1/26/2002 – 1/30/2002</td>
<td>San Diego, CA</td>
<td>For more information, visit the SCCM Web site at <a href="http://www.sccm.org">www.sccm.org</a></td>
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<tr>
<td><strong>SOCC Executive Committee Meeting</strong></td>
<td>1/26/2002</td>
<td>San Diego, CA</td>
<td>For more information, contact Sue Tellez at 847/434-7395</td>
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<tr>
<td>Annual Post-Graduate Course in Pediatric Cardiovascular Disease:</td>
<td>2/21/2002 - 2/24/2002</td>
<td>Orlando, FL</td>
<td>For more information, visit <a href="http://pedsCCM.org">http://pedsCCM.org</a></td>
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<tr>
<td>5th Annual Pediatric Acute Care Symposium</td>
<td>4/5/2002 - 4/6/2002</td>
<td>Las Vegas, NV</td>
<td>For more information, visit <a href="http://pedsCCM.org">http://pedsCCM.org</a></td>
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<tr>
<td>Pediatric Critical Care Colloquium</td>
<td>10/2/2002 - 10/5/2002</td>
<td>San Diego, CA</td>
<td>For more information, contact Hector James , MD at 858/560-4791</td>
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**SECTION ON CRITICAL CARE EXECUTIVE COMMITTEE 2001-2002**

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