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Editorial Contact: info@nightnursetriage.com

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Dear Night Nurse:

I recently learned that an article in the New England Journal of Medicine suggested that immunity to Chickenpox after immunization was incomplete. Therefore, children under 12 years of age would require a second dose of vaccine, usually at age 5, or as a catch-up dose by age 12.

I have not opted for the Varivax vaccine. I’ve remained instinctually skeptical of the vaccine all these years, having foreseen the need for “boosters”, and the fear that these immunized youngsters, will get the Chickenpox as adults. Because of other children being immunized, my child has not been exposed. My child is up to date on all other immunizations. What should I discern from this article?

I’d appreciate your input,
A concerned parent

Dear Concerned Parent,

The article from the NEJM simply re-enforced what many of us suspected, that a booster dose of Varivax would be necessary. Even in the days when everyone acquired chickenpox the old fashioned way, clinicians saw lots of children who got chickenpox more than once. What this proved was that immunity to certain infections is incomplete, even after natural infection, (witness RSV, Pertussis, and Varicella). The intent of Varivax was to immunize folks so as to avoid the complications of natural Varicella (and yes, I in 30 years of practice have seen them all—pneumonia, cerebellar ataxia, encephalitis, and my personal least favorite, flesh eating strep. We also expect to see a significant drop in shingles (Zoster), with immunization. If you know someone who has had shingles, they’ll tell you it is no walk in the park. By having your youngest not immunized, you have not avoided risk, but you have accepted a different level of risk, which with most folks immunized is not insubstantial. I had a professor in medical school who would say that rare illnesses are only common in the people who have them—that’s true. You are trading off the “better” level of immunity with natural infection in the fervent hope that your child will be one who won’t have a complication. But remember what I said? Even in the “old days”, patients got Chickenpox more than once. Some of the sickest patients you will ever see are adults with chickenpox. Therefore, it is time to allow your child to be truly up to date with his vaccines and to receive his Varicella vaccine as per this new set of recommendations.

Best regards from Night Nurse,
Dr. Peter D. Rappo
Wake Up Massachusetts!

Why we need to go “Compact” by Roy Pologe, CEO, NN

Few MA physicians are certified to practice in VT, though Medicaid, HMO, and medical insurer guidelines, do not inhibit, or prohibit patient care by physicians across state lines. Recently one of our staff RNs encountered an after-hours triage call from VT patient of MA medical practice. Our nurse triaged the call, but noted concern having done so. The nurse was credentialled in MA, and call was from VT. While patient’s physician and practice was verifiably in MA, was our RN correct in triaging patient resident in VT? We didn’t dismiss our nurse’s concerns, and the incident described resulted in conversation with the VT Board of Nursing.

“Your nurse was in violation of both VT, and MA nursing regulations”, said the VT BoN. “Why is that”, our Director of Nursing Triage Services inquired? “We’re allowed to triage MA resident patients who travel out of state. What makes this situation so different? How should we have assisted the patient?” We were then advised by the VT BoN to re-direct VT patients to their physician for triage. The VT patient’s physician being in MA was not of similar concern, as VT BoN doesn’t have “authority to police physicians”.

Certainly, the encounter described surfaces questions for further discussion. But practically considered, by following VT BoN guidelines, the patient in question would have had care advice considerably delayed, alternately dialed 911, or gone on their way to the nearest ER. Possibly all alternatives would result in reasonably positive outcomes, [aside from added medical costs accrued the practice, HMO, government, and needless risk for the VT patient].

But, if circumstances surrounding the call were life threatening, (for instance symptoms akin to meningitis), the scenario endorsed by VT BoN, and deemed acceptable policy by the MA BoN, could have resulted in death or serious complications for the patient.

Night Nurse triaging that VT patient was an oddity. It was also an eye opener.

In-common accreditation of nursing credentials throughout New England, would expedite delivery of qualified cost efficient medical services benefiting all concerned. Our staff RNs average 15 years of pediatric experience and their primary concern is delivering competent, understandable care advice to patients of our 500 subscribing pediatricians. Since 1999, our nurses have effectively triaged over 300,000 patient encounters without incident. Patients in VT or any other state may expect exemplary triage from our MA and CT registered RNs/NPs.

Current nursing regulations enforceable by the MA BoN* and endorsed by the VT BoN are possibly antithetical to good medical practice. The absurdities of these regulations may be more self-serving than life saving. Regulatory authority that deters achieving good patient outcomes must be thoughtfully examined, and thoroughly revised.

Then surprisingly we discovered document #1288, a bill proposed by Senator Richard T. Moore, languishing unheralded in the MA legislature.

Senator Moore wants Massachusetts to join an existing “compact” of 22 states united by the proposition that nursing credentials properly issued in any of those states are acceptable in all “compact” states. Neighboring New Hampshire and Maine are two of these twenty two states.

Commonwealth affiliation would mean RNs/NPs certified in Massachusetts could minister to patients in 22 other states, without requiring separate application for certification in each “compact” state. Delivery of timely triage across state lines could alter life threatening outcomes.

I’m respectfully requesting the New England medical community to actively support passage of Senator Moore’s legislation, empowering Massachusetts to join 22 united states, in “compact” observance of each other’s nursing credentials.

On October 24, 2007 at 10:00 am, the Joint Public Health Committee will take testimony on this bill at the Massachusetts State House in Room A-1. To support its passage, please contact your State Senator and State Representative asking them advocate for it before the Committee on Public Health.

For further information, and to indicate support for Senator Moore’s legislative proposal, e-mail info@nightnursetriage.com

* MA BoN Regulations, Section 244 CMR 9.00 sub section 4/9.03 : reads in effect; triage of out of state resident by MA RN is violation of statute. Regulation never tested, open to interpretation. NN staff abides by MA BoN Regulations. NN RNs/NPs presently credentialled in MA/CT.
Retail Based Clinics: 
by Peter D. Rappo, MD, FAAP

When most physicians see the initials RBC, the traditional association is “red blood cell.” In this brave new world of medical evolution, the RBC acronym now refers to retail based clinics. Those of us in practice for an extended period of time, can recall walk-in clinics that catered to the concept of patient convenience. These entities usually were run by an individual physician, working during hours when other physicians might be unavailable.

Walk-in clinics were touted as alternatives to emergency room care, but since managed care organizations did not provide insurance coverage, the so-called “Doc-in-Box” entities were largely unsuccessful.

However, newer clinic programs are being backed by some of the giants in the health-care and retail pharmacy industry, such as Wal-Mart, Walgreen’s, CVS and others. These newer walk-in clinics will primarily be touted as quick and easy alternatives to waiting in physician’s offices. An understandable concept if access to medical care was a challenge; but in urban areas, there is usually not an inordinate wait to see a physician, (at least in pediatrics).

The American Academy of Pediatrics has long endorsed provision of comprehensive, coordinated and compassionate care to an individual patient, provided by an individual primary care physician and his/her practice infrastructure. Retail based clinics would directly compromise this concept.

Let’s pose some hypothetical questions. Is competition necessarily a bad thing? Short answer is no, as long as the competitors have a level playing field. There are some indications insurers, contracting with RBCs may waive co-payments. This disadvantages primary care physicians and will increase RBC utilization. We should recall, co-payments were introduced to our office is appropriate, since we cannot make those assessments without seeing the patient. Therefore, bottom line cost of care is likely to increase, due to redundant visits that could have been avoided, save for concept of convenience.

could represent a more severe or potentially grave situation.

We may also question whether an inherent conflict of interest exists for an NP employed by a pharmacy, in terms of their ability to write prescriptions in an unbiased fashion. Although pharmacies may first run retail based clinics as a loss leader, they will ultimately want to turn a profit on this endeavor. Can we assume prescriptions will be written in the best interest of the patient, rather than the best interest of the pharmacy? [To avoid potential conflicts of interest, my simple suggestion is that when the NP writes a prescription at the drugstore, it can only be filled at a competing pharmacy chain. Not a likely scenario, but at least it resolves the conflict of interest question.]

Pediatricians make sure ill children can be seen in real time and not geologic time. I don’t think patient access is quite as open with internists and family practitioners for adult patients. While convenience appeals to a variety of patients who procrastinate when obtaining medical services, it seems illogical that patients will be satisfied with the opinion of a walk-in center after they leave, prescription in hand. Patients often question the care rendered by my board certified associates, and contact me to make sure I agree with their treatment plan. It’s my belief that most of us, when asked the same question about a treatment plan, after the patient is seen at an RBC, will suggest a visit to our office is appropriate, since we cannot make those assessments without seeing the patient.

Table: The Nurse Licensure Compact - S. 1288
Proposal filed by Senator Richard T. Moore

The compact works similarly to other reciprocal licensure agreements in professions like teaching. It allows nurses to have one license in his or her state of residency and to practice physically or electronically in any other state that has also adopted the compact. States where the Legislature adopted the compact, adopt administrative rules and regulations for its implementation.

Presently, 22 states have joined the compact including Maine and New Hampshire. Rhode Island and Colorado are currently implementing the compact and will become full members in the next year. Joining these states, Massachusetts enhances its ability to attract high quality nurses to staff teaching and community hospitals and health care institutions across the state. It makes it easier for licensed nurses to work in Massachusetts in the event of a disaster and encourages our nurse consulting/staffing firms and providers of nursing triage services, to expand their operations beyond Massachusetts.

Office of Senator Richard T. Moore
State House, Boston, MA 02133-1053

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In 1992, The American Academy of Pediatrics issued their policy statement recommending that infants be placed on their back or sides for sleep in an effort to reduce the incidence of Sudden Infant Death Syndrome. The basis for this recommendation evolved from anecdotal observations by pediatricians that prone sleeping was associated with a higher incidence of SIDS than back or side sleep positioning. The good news is that the incidence of SIDS has now decreased by a factor of 1/3 in the United States. However, the unanticipated consequence of such sleep positioning has been a virtual epidemic of head flattening in infants.

The AAP was first contacted by pediatricians in 1996 due to concerns that some neurosurgeons were operating on infants who had altered head shape in the absence of craniosynostosis. It is imperative that pediatricians, when evaluating a child with an altered or aberrant head shape distinguish between these two entities. Craniosynostosis suggests that there is a premature fusion of one or more skeletal sutures. Plagiocephaly suggests that the head is simply molded or deformed by the child lying regularly in the same position for sleep. The AAP did take a strong position about the inappropriate nature of operating on children with non-synostotic deformation. However, it also became increasingly obvious that children born with a concurrent torticollis of the neck muscular had an increased risk for more severe plagiocephaly. As any pediatrician knows, the infant skull is quite deformable. All of us have seen “conehead” equivalents that have done well over the first six months of an infant’s life. It should also be noted that cranial remodeling helmets were first piloted for infants who had completed craniosynostosis surgery in an effort to remodel head shape. However, the clinical data regarding their safety in infants with simple plagiocephaly is at best scant.

Any condition that is perceived by parents as a departure from the norm will seemingly demand a medical or surgical corrective response. An industry has sprung up to offer patients corrective devices, bands, or helmets to correct infant plagiocephaly. More disturbing, perhaps, are the myriad of web sites that have been created around the treatment of the new diagnostic entity of “plagio.” A Google search of the term plagiocephaly will immediately draw the researcher to parent support web sites and vendors who are pleased to provide families with data about the availability and cost of these corrective devices. What do we know about the safety and efficacy of cranial remodeling devices? The answer is surprisingly little. What we can safely say is that parents are convinced that they are necessary for their children to have a normal appearance, parents are concerned that other complications such as brain damage, seizures, TMJ syndrome, hearing loss, and ear infections are a consequence of non-correction. The literature about untreated plagiocephaly is also exceptionally scant in that there are apparently very few patients who are inconvenienced by their “abnormal head shape.” One study did suggest that a rhomboidal transformation of the head is most often appreciated in adults by an oculist, in other words, an eye doctor will sometimes find that one arm of a pair of eyeglasses will need to be longer than another to appropriately fit a patient’s face.

There are undoubtedly patients whose plagiocephaly is so severe that a remodeling device may be warranted. However, at this time, there is little agreement as to what constitutes severe involvement based on CT, MRI, skull film, or volumetric data. Most patients will have their deformation corrected by pediatricians simply suggesting to parents that they vary the direction that the child’s head is facing from night to night, that they aggressively screen for torticollis, and that if the child’s motion is limited that a pediatric physical therapy program to gently stretch neck muscles be pursued. Of equal importance is the concept that during awake times, children should be placed on their abdomens on a firm surface such as a blanket lying on the floor. This intervention will not only assist in the child’s global motor development (notice how all the infants are behind nowadays due to the sleep position recommendation) but will also round out the child’s head. The nature of pediatric practice is to practice high quality care in a thoughtful environment and to use anticipatory guidance as an opportunity to improve patient outcome and to decrease avoidable morbidity and unnecessary interventions. The treatment of infantile plagiocephaly provides the practitioner to do good for their patients.
Making recommendations for proper transport of children requires knowledge of state regulations and expert, tested information. Massachusetts state law requires children to ride in child passenger restraints until they are at least five years of age and weigh 40 pounds. Infants should ride in a rear facing seat until they are at least one year old and 20 pounds. The rear facing position is always safer and may be continued beyond age one in a proper sized safety seat. Infants in rear facing car seats should never be placed in the front of a car containing air bags.

Children who weigh between 40 and 80 pounds and are less than 4’9” tall should ride in a booster seat. Booster seats enable the vehicles lap and shoulder belts to fit properly and also allow children to see better and ride in greater comfort. The Massachusetts Chapter of the American academy of Pediatrics supports legislation mandating booster seat use. Children under the age of 12 who have outgrown safety seats should be belted and in the rear whenever possible.

In Massachusetts, the law requiring children to use car seats or seat belts is primary to age 12, meaning that a vehicle carrying youngsters aged 12 and under may be stopped solely to enforce child safety regulations. Once children are older than 12, a vehicle may be stopped for another reason to allow enforcement of safety belt use (a distinction the Massachusetts Chapter of the AAP has been actively trying to change). Whatever Child safety seat or booster is being used, always advise parents to follow manufacturer’s instructions (attached, by law, to all approved safety seats) for installation and for determining a proper fit for each seat. The newer LATCH (Lower Anchors and Tethers for children) system being phased in is an effort - thus far only partially successful – to simplify the installation of seats.

There now exists a national network of rigorously trained Child Safety Technicians who provide cost – free educational demonstrations of the proper use of child safety seats to parents and caregivers. To locate a technician in Massachusetts, call 978-392-5956 or visit www.massscps.org on the web.

Finally it should be noted that for many children in the three-to-six year range, seat belt use becomes a fertile ground for trying to assert control. Parents must be reminded that for many reasons, this issue is non-negotiable. Aside from the concept of power struggles and how to handle them, “safety first” should reign here. If necessary the child may have to be left home with a sitter or plans be put off. In this case the bottom line is no compromise.

Dr. Schreiber can be reached at 508-894-0655 or pschreiber@bgpma.com by individuals supporting either of the legislative efforts mentioned above.

Other sources for child passenger safety are:
Massachusetts Injury Prevention and Control Program at 617-624-5070 or www.mass.gov/dph/fch/injury/index.htm
Car Safe Toll free at 1-800-CAR-SAFE

Comments from Robert Sege, MD, PhD, Chief of the Division of General Pediatrics and Adolescent Medicine, Tuft’s New England Medical Center.

Dr. Schreiber has provided an excellent, comprehensive overview of the benefits of child safety seats. The widespread use of booster seats has been a relatively recent development, but a much needed one. Look at his graph taken from an article by Flaura Winston and colleagues that appeared in JAMA in 2003 (BPB are belt–positioning boosters). Data based on national insurance claims, demonstrate that children under 7 in booster seats are dramatically safer than those wearing seatbelts alone.
Now that the weather has gotten decidedly warmer, it is an opportunity to get the kids outside more often. In the suburbs of Boston, however, you should be aware that the ticks that transmit Lyme disease are awaiting the next warm blooded body that passes by.

Lyme disease is caused by a bacterium called Borrelia burgdorferi. These bacteria are carried in the guts of deer ticks. Dog and cow ticks do not carry the Lyme disease bacteria. There were about 23,000 cases of Lyme disease reported in the United States in 2002.

In the youngest phase of development called the larval stage, a deer tick is no bigger than the head of a clothes pin. The adult deer tick is about 1/8 of an inch long. These arthropods have eight legs, and the deer ticks tend to lack any type of lines on the body of the tick. Any tick that is close to 1/4 inch long is probably not a deer tick. Ticks tend to wait in grass and on twigs. They hang on to their perch with the lower six legs and extend the top two legs in anticipation of a passing animal or human.

Typically, the symptom of a bull’s-eye rash at the site of a tick bite will occur within one to two weeks, but may take as long as a month to develop. In about half of cases of Lyme disease, the initial bull’s-eye rash was never seen. Scattered bull’s-eyes and other symptoms such as nasty headaches, muscle aches, weakness, fever, joint pain, limping, heart rhythm problems, and a facial droop typically develop within a month of the tick bite.

Now that I have you sufficiently uncomfortable, I will tell you the good news about tick bites. A tick that gets on your body will typically spend a few hours walking around before it finds a nice warm spot to feed. Many older children and adults will actually feel an adult tick biting into the skin and will be able to identify a tick bite immediately. According to the Centers for Disease Control and Prevention (CDC), it is unusual for a tick to pass along the Lyme disease bacteria until it has been feeding for at least 36 hours. If you find and remove a deer tick within this amount of time, the odds of catching Lyme disease are extremely small.

Prevention of Lyme disease includes wearing light colored clothing so that it is easy to identify tics walking around before they feed. Wearing socks on the outside of long pants will help prevent a tick from attaching to the skin, and insect repellent containing DEET is effective for preventing tick bites. You should perform a tick check on a daily basis if your child has been outside. For example, a check of the entire body at bath time can be invaluable. Look for anything that looks like a new mole, especially if the mole moves! Take extra care to look through the scalp since feeding ticks can hide on the head. The good news is that parents who find the tick are much less likely to have a child with Lyme disease.

Removal of the tick is important and should be done with fine tweezers. Grab the tick at its head and pull back slowly but firmly. If the tick mouthparts stay behind, there is no reason to worry since the Lyme bacteria is stored in the body parts of the tick. Warm soaks will help prevent skin infection at the site of the tick bite. A small patch of redness at a tick bite site does not indicate Lyme disease. If this rash becomes wider and develops a pale center over the next few weeks, this is an important sign and you should call your pediatrician.

Lyme disease can be treated with antibiotics, but every child with a tick bite should not be treated with antibiotics. Since quick removal of a tick essentially prevents Lyme disease, antibiotics may only cause your child unnecessary discomfort from side effects and provide no benefit. After a tick bite, you should examine the bite area twice a day for a week or two to look for the bull’s-eye rash, and you should keep the tick bite in the back of your head for the following month in case your child develops any of the secondary symptoms listed above.

Dr. Chung received his medical training at Harvard Medical School and Children’s Hospital. He practices primary care pediatrics at Pediatric Associates of Brockton.
NNNews Reports:

SHOULD MA GO COMPACT?
Proposed nurse licensure legislation.

RETAIL BASED CLINICS?
Patient, physician, insurer concerns.

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