Lucile Packard Children's Hospital AT STANFORD

PHYSICIAN UPDATE

A PUBLICATION FOR REFERRING PHYSICIANS

SUMMER 2004

LPCH'S NEW CENTER FOR HEALTHY WEIGHT WILL PROVIDE COMPREHENSIVE STRATEGY TO PREVENT AND TREAT OBESITY

CENTER BRINGS TOGETHER A WIDE ARRAY OF SPECIALISTS

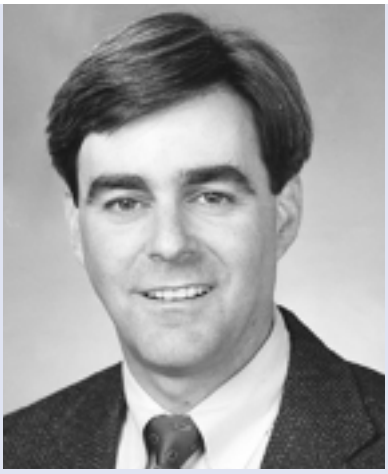
Overweight and obese children face an uphill battle to control their weight and minimize the serious medical consequences of their condition. Although many recent reports show an alarming increase in the numbers of affected children in this country, comprehensive strategies for dealing with the problem are lacking. Lucile Packard Children's Hospital is developing a new Center for Healthy Weight to provide a unique, comprehensive program to prevent and treat obesity and the related medical fallout that comes hand-in-hand with excess pounds.

> "Prevention is clearly better than treatment," says Cohen, "and early intervention is a whole lot better than trying to treat obesity after co-morbid diseases have already occurred."

"A lot of physicians feel frustrated and powerless when it comes to dealing with children and obesity," says center director Tom Robinson, MD. "The center will focus on providing solutions by linking basic science, clinical research, medical care and community-based prevention. We'll continue our work with community health programs and form new partnerships to create healthier environments for children, while at the same time providing comprehensive medical care for overweight kids."

Solutions for preventing and treating obesity in children are urgently needed. Although extra pounds are not yet a leading cause of childhood death, they do lead to life-threatening medical problems in adolescence and adulthood. The increasing prevalence of childhood obesity has led the Centers for Disease Control and Prevention to estimate that one in two African American and Hispanic children and one in three of all children will develop type II diabetes in their lifetime. Obesity-related conditions are already responsible for about 400,000 deaths each year, trailing only smoking as the leading killer in this country.

"Now insulin resistance, which is a type of pre-diabetes, kidney and liver damage, and orthopedic problems are starting to affect children as well," says Robinson, associate professor of pediatrics and medicine at Stanford University Medical School, "and the morbidity seems to be much worse than in adults. Children are living with this excess fat in their organs from very early ages."



TOM ROBINSON, MD
director of Center for Healthy Weight at LPCH

"Obesity is the biggest epidemic that we face right now," says LPCH chief of staff Harvey Cohen, MD, who is also the Arline and Pete Harman Professor for the Chair of the Department of Pediatrics. "Even those obese kids who escape medical problems during childhood will likely have medical problems as adults. Mortality from tobacco, alcohol, and traffic accidents will pale in comparison to the effect obesity is having and will have on the health care system."

"Lucile Packard Children's Hospital is unique in terms of our expertise across so many different disciplines," says Robinson. "We have state-of-the-art clinical facilities in which we provide primary care management and assessment for obesity risk factors. We

Continued on next page

IN THIS ISSUE:

LPCH'S NEW CENTER FOR HEALTHY WEIGHT WILL PROVIDE COMPREHENSIVE STRATEGY TO PREVENT AND TREAT OBESITY

CENTER BRINGS TOGETHER A WIDE ARRAY OF SPECIALISTS

Continued from cover

also conduct clinical research into methods of weight control such as different nutritional therapies and clinical trials of new pharmacological treatments."

In the coming fall and winter, the current Pediatric Weight Clinic, which now operates for two half-days every month, will move to Castro Commons in Mountain View and double its hours of operation.

"Our mission will be to provide a comprehensive, multidisciplinary evaluation of significantly overweight patients," says Lawrence Hammer, MD, medical director of the hospital's ambulatory care center and professor of pediatrics at the medical school. "Some need evaluation of comorbidities such as type II diabetes or obstructive sleep apnea, and others may need ongoing monitoring of their health status. Each patient will receive a complete initial evaluation by general pediatric or adolescent medicine staff, including a review of their past history and a physical exam that includes appropriate diagnostic testing. The evaluation will also include meeting with a dietician and the development of dietary and physical activity goals. We will also work closely with our colleagues in child psychiatry to address the psychological impact of overweight in the life of the patient and his or her family."

LAWRENCE HAMMER, MD
director of Outpatient Services for Center for Healthy Weight

One tested method used in the current pediatric weight control program involves a series of weekly group meetings where parents and children get together separately and focus on elements of behavioral treatment of obesity and overweight. Members of each group learn how to keep dietary and physical activity records and how to understand behavioral cues that may lead to overeating. Positive reinforcement is emphasized as a way to meet goals.

"It's important to be able to provide well-developed, scientifically and clinically studied treatment approaches," says Hammer. "This is the only behavioral approach that has been extensively studied."

Cultural and ethnic differences among population groups can also affect obesity prevention and treatment efforts. Understanding and working within these differences will be important goals for LPCH physicians at the center.

"Ethnic and social differences need to be addressed," concurs Cohen. "Unless we work within the expectations of the different communities from which these kids come, we are not going to be effective."

"Depending upon the patient's clinical situation, we will tailor our management approaches to what the patient and family members are most interested in," says Hammer. "All the approaches include diet modification and increases in physical activities, but in varying ways."

Occasionally severely obese patients need more aggressive treatment because they are preparing for an upcoming surgery or because the condition is not responding to traditional treatment.

"Aggressive low-calorie diets can be very effective and safe if medically supervised," says Hammer, "and if bariatric surgery is necessary to control weight gain, we are in the right place to evaluate, manage and standardize the procedure."

"There are a small number of teens for whom bariatric surgery may turn out to be their best or only option," says Robinson. "The reason we're considering these measures is the growing number of teens with life-threatening obesity. As the population gets heavier, it behooves us to evaluate the potential benefits and harms of much more intensive treatments."

Physicians at the center will work closely with a child's primary care physician to devise a treatment plan.

"We hope to provide patients, their families, and their primary care physicians a lot of guidance in terms of their ongoing medical supervision," says Hammer. "We will be available to provide whatever level of ongoing follow-up seems reasonable in consultation with the primary care physician."

But Robinson, Cohen and Hammer would prefer to root out the problem at its source. "Prevention is clearly better than treatment," says Cohen, "and early intervention is a whole lot better than trying to treat obesity after co-morbid diseases have already occurred."

Robinson and his colleagues at the Stanford Prevention Research Center have produced some of the most successful obesity prevention studies, ranging from curricula to reduce television watching to after-school dance classes. They continue to evaluate innovative community-based strategies with funding from the National Institutes of Health.

"The synergy that exists between Stanford Medical School and Lucile Packard Children's Hospital should yield a multi-faceted, integrated approach that can help these children," says Cohen. "Although we're beginning to deal with this problem now, we realize that this effort is more of a marathon than a sprint. We're in this for the long haul, and we hope through continuing program development we can make a difference that will be long-lasting and meaningful."

For more information about the Pediatric Weight Clinic or to refer a patient, contact program coordinator Susan Farrales, RN, at (650) 736-2114 or visit http://pediatricweightcontrol.stanford.edu.

BLADDER EXSTROPHY SUPPORT GROUP A RARITY ON WEST COAST

FAMILIES COME TOGETHER TO SHARE EXPERIENCES

Bladder exstrophy is a relatively rare congenital condition with resounding medical and psychological implications for infants and their parents. Although the condition is sometimes diagnosed prenatally, many couples don't know in advance that their baby will be born with the complex anomaly, which usually requires several surgeries throughout the child's early life. The division of urology at Lucile Packard Children's Hospital sponsors the only support group in Northern California to bring family members and patients together to share information, provide moral support and reinforce a sense of community in children and young adults with the condition.

"Families want this support group for their kids," says LPCH pediatric urologist Jennifer Abidari, MD. "They want to know 'How can I help my child feel OK about themselves?' They're also looking for positive adult role models with exstrophy to provide inspiration and reassurance, and give their children a sense of worth and value."

Bladder exstrophy, affecting about one in every 250,000 to 500,000 newborns, is caused by a failure of the lower abdominal wall to form correctly during embryonic development, exposing the interior of the bladder and urethra. In the most severe cases, the bowel is also exposed, while a more mild form is confined to a urethral defect or opening. Pelvic bones are also often widely separated.

Newborns with bladder exstrophy are usually born at full term, and are otherwise healthy. Bladder closure and remodeling, as well as pelvic bone closure, is usually performed immediately, and may require a cast for six to eight weeks after birth. In girls, genital reconstruction, if necessary, may also be accomplished at this time. Reconstruction of the penis and urethra in boys is usually performed between one and two years after birth. Additional surgeries at two to three years of age to restore continence and at around ages six or seven to increase bladder size are also frequently needed.

"In addition to multiple surgeries, there are obvious psychological repercussions," says Abidari, "including problems with self-esteem and genital perception. One of the most devastating things about the condition is the impact on the kids' sense of worth and value. Genital appearance and continence go right to the darkest part of a person's sense of body. When does a teen with exstrophy explain to his or her peers, 'By the way, I'm not going to look like everyone else from the waist down'?"

About 20 families in the Bay Area participate in the California Bladder Exstrophy Support Team, or BEST, which was started about three years ago by Abidari and Stanford employee Doug Kreitz. Kreitz and his wife adopted an infant from Russia with bladder exstrophy several years ago, and are active in the group. The group has an annual meeting in May and an annual South Lake Tahoe camp-out in August.

"Some people are not defeated by this condition, but for others it's exceptionally difficult," says Abidari. "We just want to make sure people know there is a support group in which children and adults with bladder exstrophy can come together and get support from each other."

For more information or to join the support group, contact Doug Kreitz at californiabest@earthlink.net. For general information about bladder exstrophy, visit the Association for the Bladder Exstrophy Community at www.bladderexstrophy.com.

ANN M. ARVIN, MD, chief of pediatric infectious disease at LPCH and the Lucile Salter Packard Professor of Pediatrics at Stanford University Medical School

ARVIN RECEIVES ALBION WALTER HEWLETT AWARD

Ann M. Arvin, MD, chief of pediatric infectious disease at Lucile Packard Children's Hospital and the Lucile Salter Packard Professor of Pediatrics at Stanford University Medical School, received the Albion Walter Hewlett award during medical grand rounds in July 2004. The Hewlett award was established in 1983 to honor physicians with a Stanford background who serve as dynamic role models and practitioners of scientific medicine. Awardees also display care and skill in a quest to help their patients live productive lives through the discovery and use of biological knowledge.

Arvin's presentation 'Varicella-zoster Virus Infections: Pathogenesis and Clinical Management' described her past work and future research on varicella-zoster virus, which causes chicken pox and shingles. Her research has led to the development of a vaccination against varicella-zoster virus. By preventing or reducing the severity of chicken pox in immunized healthy children, the vaccine can reduce the likelihood that immunocompromised people will contract the disease. Arvin's research also suggests that boosting the immune response to the virus prior to hematopoetic cell transplantation can reduce the subsequent risk of shingles. She is currently conducting a study to determine whether vaccination can provide elderly people with a similar benefit.

CHILDREN WITH DEVELOPMENTAL PROBLEMS RECEIVE ONGOING EVALUATIONS AND CARE

UNIT'S MULTIDISCIPLINARY NATURE HELPS PARENTS AND PATIENTS

The special medical and social needs of premature or high-risk infants continue after they go home from the hospital. The Mary L. Johnson Development and Behavior Unit of Lucile Packard Children's Hospital brings together multidisciplinary specialists to diagnose and coordinate ongoing care for these children from infancy through adolescence.

"Many obstetricians are unaware of the resources that Packard Children's Hospital has to support a premature or high-risk infant after they are discharged," says program manager and nurse practitioner Anne DeBattista. "We provide one-stop shopping service for families. They can come to the clinic and receive coordinated information and recommendations from a host of different specialists, rather than having to manage their child's care and navigate resources on their own."

Formerly known as the Infant Development Unit, the program has been renamed to emphasize services for older children as well as infants, and for children with other medical complications during infancy besides prematurity. Under the auspices of both the Johnson Center for Pregnancy and Newborn Services and the Harman Clinic, neonatologists, pediatricians, neurologists, psychiatrists, neuropsychologists, educational specialists, speech and language experts, nutritionists and physical and occupational therapists collaborate to provide assessment, diagnosis and referral to appropriate hospital and community-based intervention services from birth through the school years.

"We're the only multidisciplinary team in the region that coordinates joint diagnostic assessments with neurology, psychiatry and neonatology," says DeBattista. "These 'brain and behavior' evaluations facilitate diagnosis and allow earlier treatment by identifying the relevant concerns and connecting them to available resources throughout the community."

The unit's inpatient developmental team works with parents, physicians and nurses to provide supportive care to babies in the intensive care nursery.

"We're teaching parents how to read their baby's cues and support their baby's developing nervous system," says DeBattista. "The team prepares families for discharge and connects them to important community resources necessary for hospital-to-home support. Our follow-up clinic can assess their progress and identify emerging medical needs."

The high-risk infant follow-up program monitors the developmental progress of infants who have been discharged from LPCH's neonatal intensive care unit. Many of these infants weighed less than 1,500 grams at birth, required assisted ventilation for more than 48 hours during the first 28 days of life, exhibited cardiorespiratory depression at birth, or had intracranial abnormalities or surgical correction of a congenital defect during the neonatal period. Infants suffering from intrauterine substance exposure, hyperbilirubinemia or other neurological problems are also followed.

The unit's developmental consultation program evaluates children ages 3 and under born throughout the Bay Area whose medical history or premature birth place them at risk for developmental problems, or whose parents or physicians are concerned about their development. After an extensive developmental assessment, families are counseled about their options for treatment and available community resources.

Finally, the Preemie Graduate Services Program provides continuing medical access to older children who were born prematurely. Specialists meet several times with the family to address the ongoing challenges facing these children.

"We often focus on setting them up for educational success," says DeBattista. "Parents frequently know before the school does when their child begins to struggle. We talk about what the family's concerns are, and develop strategies to address those concerns. There may be fine motor issues or undiagnosed cerebral palsy. Other children may exhibit difficulties with language or memory, or there may be psychological or behavioral issues. We try to connect the child's medical history with these complications, allowing parents to understand their child's strengths and difficulties and support their development."

ANNE DEBATTISTA, RN, program manager and nurse practitioner at Mary L. Johnson Development and Behavior Unit of LPCH

The unit recently received a three-year $1.1 million continuation grant from First 5 San Mateo County for a project designed to improve coordination of care, facilitate access to early intervention services and provide ongoing support to families of premature infants.

In addition to providing comprehensive clinical care to hundreds of children over the past several years, specialists at the Development and Behavior Unit are constantly evaluating ways to improve the delivery of care to the children and their families.

"We're looking at service delivery, relationship of service to outcomes and barriers that hinder best practices," says DeBattista. "We're trying to increase collaboration between the hospital and the available community services to speed up the referral process, and to give the families timely access to the services they need."

For more information about the Mary L. Johnson Development and Behavior Unit, call (650) 725-8995 or visit http://dabu.lpch.org

BREASTFEEDING PREMATURE INFANTS BENEFICIAL, DIFFICULT

ONGOING STUDY AIMS TO INCREASE SUCCESS RATE

Most of us wouldn't associate the gentle whir of a breast pump with the neonatal intensive care unit. But premature babies who receive breast milk leave the hospital an average of two weeks earlier than those who are formula-fed, and they are less likely to suffer from life-threatening infections or bowel disease. Providing breast milk is also a concrete way that mothers can participate in the care of their babies.

"Many mothers who deliver prematurely feel that they have abdicated the care of their babies to the high-tech nursery," said Jane Morton, MD, director of the Breastfeeding Medicine Program at Lucile Packard Children's Hospital. "Providing breast milk is one vital connection that can be more useful than many of the medical procedures we can offer a baby."

> Providing breast milk is one vital connection that can be more useful than many of the medical procedures we can offer a baby.

The difficulties of breastfeeding increase exponentially, however, when a premature baby is too small, weak or uncoordinated to nurse effectively. Mothers must rely on breast pumps to extract the milk for their infants. Morton recently received a $160,000 grant from the Medela Corporation to study which breast pump models are most effective in helping a new mother establish and maintain a healthy milk supply.

"Some mothers are pump-dependent for months," said Morton. "The tinier the baby is, the longer the mother is going to need to use the pump. However, because milk production plateaus after the first two weeks, it's really important to ramp up quickly even though the baby is still very small."

Establishing a high volume of milk early is critical to allow the baby to eventually switch from feeding tube or bottle to breast, said Morton. "Without that volume, the milk is too difficult for the baby to extract, setting the mothers up for early termination of breast milk feeding." Frustrated and tired moms, who must offer their babies a bottle after first trying to breastfeed, may not have the stamina to follow up with a pumping session to empty their breasts and stimulate more milk production.

Mothers of premature babies weighing less than 1,500 grams who choose to participate in Morton's study will be randomized to one of two breast pumps: one with a special "pre-letdown" setting, and the other a standard model with only the extraction pumping pattern. Morton will then compare the volume of milk produced by mothers using each pump.

Another phase of the study will compare letdown intensity and milk production volumes with breast shields of varying size, shape and texture. "The manufacturers are finally addressing the obvious," said Morton. "Not all women are shaped the same."

Morton will also be collecting breast milk samples from women once a day during the first two weeks, and then once a week for the remainder of the six-week study. She'll look at the amounts of about 20 common components and track how they change over time.

"This is the really exciting part of the study for me," said Morton. "We're interested in how the milk may vary between moms whose babies were born at different gestational ages. Are the levels of some components, like protein, higher in some women, and do they vary throughout the course of the day? We know that breast milk from women who deliver prematurely tends to have higher protein and salt content, and it will be very interesting to see how these and other levels may change as the baby ages."

JANE MORTON, MD, director of Breastfeeding Medicine Program at LPCH

Most breast milk fed to premature babies in this country is fortified with calcium, protein and other components based on biochemical markers in the baby's blood. Morton's research may help physicians decide if and when fortification is appropriate.

"We need to learn more about handling a premature baby's nutritional needs," said Morton. "As mothers enroll in this study and become dedicated to pumping at high levels, the benefits for mother and child may become more evident to the staff who care for them. At the same time, providing their own milk to nourish and protect their infants can help mothers heal from the emotional devastation that can be brought on by premature delivery."

For more information about the study or to speak with Jane Morton, call 650-724-9653 or 650-723-5711 or email mortonj@stanford.edu .

MANY LPCH CLINICS MOVING OUT OF MAIN HOSPITAL

RELOCATION MAKES WAY FOR HOSPITAL EXPANSION

Beginning in October, all Lucile Packard Children's Hospital clinics on the first floor of the main hospital, except hematology/oncology and cardiology, will be relocated to allow the Phase I of the LPCH Facility Plan to go forward. This eagerly awaited hospital remodeling project is designed to expand capacity and enhance the patient experience while improving patient care.

Many of the clinics will be relocated across the street from the main hospital to 730 Welch Road, adding space, child-friendly exam rooms and adequate parking for patients and staff. Other clinics will be moving a bit further down the street or—in the case of adolescent medicine—to Mountain View.

When the construction is completed, the hospital will gain many new things: 27 inpatient beds, six state-of-the-art operating rooms, a Pediatric Blood Disease and Oncology Center, and a pediatric dialysis unit designed as much for patients and family members as for physicians and hospital staff.

"This is a very exciting time," says Susan Flanagan, the hospital's COO. "We're going to be better able to serve our patients with an increased number of beds and provide an Oncology center that is much more patient-friendly and has better integrated inpatient and outpatient components. Perioperative, surgical and post operative care will be located near one another on the ground floor and will be very family-focused. The benefits will be tremendous."

"We are committed to making the clinic experience as user-friendly as possible," explains Michael Link, MD, chief of oncology. "The idea is that the patient is sometimes an inpatient, sometimes an outpatient and sometimes both. So we're trying to weave everything into one center—to make it one seamless experience."

Other changes will benefit all who enter the hospital. A newly revamped main lobby will be more inviting and informative, and new design elements will invite families to enter the hospital's halls. Though security will also be tightened through the use of visitor badges and turnstiles, most patients and staff will see only a beautifully designed institution with colorful lobbies and exam rooms and waiting rooms with video games, computers and other diversionary activities for child and parent alike.

Construction, which began with the renovation of the space at 730 Welch Road, will last about two years, with some elements completed sooner. Consolidation of cardiac services into a comprehensive Heart Center occupying the deck that overlooks the Doobie Brothers Courtyard, as well as the new dialysis unit and observation unit in the current Harman Clinic, will be complete in 2005.

The new 16,000-square-foot surgical suite, with built-in cameras for world-wide teleconferencing, 60-inch wall-mounted plasma screens, remote robotic surgical capabilities, voice-activated hardware and radiofrequency energy sources nestled in child-friendly operating rooms will be completed at the end of 2005.

MARY L. JOHNSON CENTER FOR AMBULATORY CARE CENTER

INSIDE THE HOSPITAL

- Space occupied by clinics A, B, C and D will become the Pediatric Blood Disease and Oncology Center's 27-bed inpatient unit, connected to the Day Hospital
- The Harman Clinic space will become a new dialysis center and observation unit.
- A portion of the deck overlooking the Doobie Brothers Courtyard area will house the Heart Center, comprising general cardiology, cardiovascular transplant, pulmonary hypertension, advanced cardiac therapies and pre and post-op cardiac surgery.
- Medical records will be relocated to an area adjacent to the administrative offices on the ground floor to make way for the new 16,000 square foot surgical suite.
- Lounges throughout the hospital will be remodeled. For example, the parent lounge on 3 North will be set aside for quiet rest and contemplation free of children and television, while the lounge in 3 West will be more child-friendly, including a kitchen, washing machines and a day-care area.
- 2 North will house a remodeled 20-bed cardiovascular ICU, allowing the current PICU to regain its 20 beds.
- The Johnson Center for Pregnancy and Newborn Services on F2 will gain an additional operating room for Cesarean sections.

PUBLICATIONS AND FACULTY UPDATES

NEW LPCH SURGERY SUITE

(Ground Floor at LPCH)

And in November 2005, the Pediatric Blood Disease and Oncology Center's 27-bed inpatient unit will open in spaces currently occupied by clinics A, B, C and D. The Day Hospital—slated for what is now the Acute Care Clinic—will be furnished with comfortable, homey chairs where children will receive chemotherapy and other infusions. A lab within the center will eliminate long waiting times.

As planned, the coming changes will be an eventual win-win situation. "Every clinic is going to end up in a better space," says William Feaster, MD, who is directing the clinic move to 730 Welch. The building is being equipped for wireless communication and telemedicine services to allow translators and other support staff to consult without walking back and forth across the street all day. Interior space will be decorated with wall-mounted play activities and interactive devices.

Plans call for a computer in every exam room, special waiting areas for teenagers, and beepers for patients so that they can wait outside in a landscaped garden complete with coffee cart and refreshments.

PUBLICATIONS

Persistent and selective deficiency of CD4+ T cell immunity to cytomegalovirus in immunocompetent young children. Tu, Chen, Sharp, Dekker, Manganello, Tongson, Maecker, Holmes, Wang, Kemble, Adler, Arvin, Lewis. *Journal of Immunology*. 2004 March 1;172(5):3260–7.

Investigation of neuroanatomical differences between autism and Asperger syndrome. Lotspeich, Kwon, Schumann, Fryer, Goodlin-Jones, Buonocore, Lammers, Amaral, Reiss. *Archives of General Psychiatry*. 2004 March;61(3):291–8.

Here's looking at you, kid: neural systems underlying face and gaze processing in fragile X syndrome. Garrett, Menon, MacKenzie, Reiss. *Archives of General Psychiatry*. 2004 March;61(3):281–8.

Frontal lobe seizures and uveitis associated with acute human parvovirus B19 infection. Hsu, Sandborg, Hahn. *Journal of Child Neurology*. 2004 April;19(4):304–6.

Antiviral CD8 T cells in the control of primary human cytomegalovirus infection in early childhood. Chen, Tu, Sharp, Tongson, He, Greenberg, Holmes, Wang, Kemble, Manganello, Adler, Dekker, Lewis, Arvin. *Journal of Infectious Diseases*. 2004 May 1;189(9):1619–27. Epub 2004 Apr 16.

Adipose-derived adult stromal cells heal critical-size mouse calvarial defects. Cowan, Shi, Aalami, Chou, Mari, Thomas, Quarto, Contag, Wu, Longaker. *Nature Biotechnology*. 2004 May;22(5):560–7. Epub 2004 April 11.

Efficacy of automated continuous positive airway pressure in children with sleep-related breathing disorders in an attended setting. Palombini, Pelayo, Guilleminault. *Pediatrics*. 2004 May;113(5):e412–7.

Children's food consumption during television viewing. Matheson, Killen, Wang, Varady, Robinson. *American Journal of Clinical Nutrition*. 2004 Jun;79(6):1088–94.

Linearity versus Cross-Talk: Biological Models and the Role of the Society for Pediatric Research in the 21st Century. Bernstein. *Pediatric Research*. 2004 Jun 4 [Epub ahead of print].

FACULTY UPDATE

Sheila E. Cohen, MB, ChB, FRCA, professor of anesthesia and of obstetrics and gynecology, was awarded the Distinguished Service Award of the Society for Obstetric Anesthesia and Perinatology at the society's annual meeting held in Florida in May. Cohen has been a member of the Stanford faculty since 1975 and, until recently, was director of obstetric anesthesia at LPCH. Her research has focused on maternal pain relief during childbirth (specifically relating to use of spinal and epidural opioids) and improving maternal and fetal safety during obstetric anesthesia. She is past president of the Society for Obstetric Anesthesia and Perinatology and has served on multiple committees in that society and in the American Society of Anesthesiologists.

IMPORTANT CONTACT INFORMATION

Physician Hotline for Referral & Consultation

24-hour, immediate referral and consultation

Tel. 800-995-5724
Fax. 650-843-0136
referral@medcenter.stanford.edu

Critical Care Consultation & Transport

24-hour, immediate consultation for neonatal, pediatric and maternal critical care and transport issues

650-723-7342

Hospital Page Operator

24-hour access

650-497-8000

OTHER CONTACTS FOR REFERRING PHYSICIANS

Admissions
800-995-5724 / 650-497-8221

Continuing Medical Education
650-497-8554

Diagnostic Imaging
650-497-8376

Radiologist Consult
650-497-8466

Grand Rounds
650-723-5168

Health Plan Services
650-736-1067

Medical Group Services
650-736-1067

Medical Staff Services
650-497-8566

Professional Services Billing for Physicians
650-498-5785

PHYSICIAN REFERRAL LIAISON SERVICE

Providing assistance and information to referring physicians and their staff.

Monday–Friday
8 am–5 pm
Tel. 800-756-5000
Fax. 650-498-2526
referral@medcenter.stanford.edu

CME COURSES

Pediatric Clinical Update
Oct. 2, 2004
San Ramon, CA

Pediatric Otolaryngology Update—2004
Nov. 6–7, 2004
The Ritz-Carlton, San Francisco, CA

Pediatric and Adult Pain Management
Dec. 1–3, 2004
Big Island of Hawaii, Mauna Lani Bay Hotel

Jan. 31–Feb. 2, 2005
Whistler, British Columbia

For More Information
650-497-8554 or visit cme.lpch.org

Lucile Packard Children's Hospital AT STANFORD

725 Welch Road • Palo Alto, CA 94304

Non Profit
Organization
U.S. Postage
PAID
Permit No. 29
Palo Alto, CA

Physician Update is published as part of an ongoing effort to serve the needs of physicians who refer to Lucile Packard Children 's Hospital at Stanford. To share comments or secure more information, contact:

Terry O'Grady, RN, MS
Director, Community and Physician Relations
Lucile Packard Children's Hospital
1520 Page Mill Road, Palo Alto, CA 94305
650-497-8965
to'grady@stanfordmed.org

Mary Dybdahl
Manager, Physician Referral Liaison Service
Lucile Packard Children's Hospital
725 Welch Road, Palo Alto, CA 94304
800-756-5000
mdybdahl@stanfordmed.org