



## YOUNGEST PATIENT EVER BENEFITS FROM NONSURGICAL HEART VALVE REPLACEMENT AT LUCILE PACKARD CHILDREN'S HOSPITAL VALVE DELIVERED TO THE HEART ON A BALLOON IN THE CATHETERIZATION LAB

Last fall, LPCH doctors replaced a heart valve in a 9-month-old girl without opening her chest or putting her on a heart-lung machine. And the procedure worked: The child's heart function improved dramatically.

The infant was the youngest child ever to undergo the novel procedure, in which a pig's heart valve is threaded on a balloon through a catheter and then along a wire down a large vein in the patient's neck. When the valve reaches its destination — in the pulmonary artery where it exits the right atrium — the balloon is inflated, pushing the valve into place.

Developed two years ago by a British physician, the procedure has never before been done on a child under age 7. It had been performed only once before in the United States, and the patient was an adult.

"Many young children who require valve replacement need multiple operations because replacement valves do not grow as the child grows," said Dan Bernstein, MD, co-director of the Children's Heart Center at LPCH and chief of pediatric cardiology. "This procedure could substantially reduce the number of operations that these children require over their lifetimes."

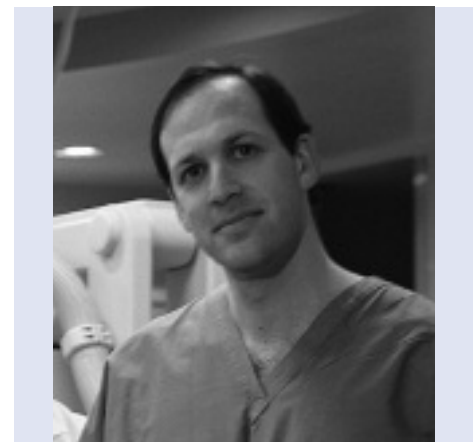
Bernstein, who is also a professor of pediatrics (cardiology) at the Stanford University School of Medicine, predicts the procedure will eventually become standard. "I could see doing this procedure on a dozen to two dozen kids each year, just at this center," he said.

The baby who received the new valve had undergone open-heart surgery when she was 10 days old. She was facing another surgery when the hospital's physicians offered the alternative of replacing the infant's pulmonary valve in the catheterization lab.

Because the child in this operation was so small, physicians had to modify the British procedure in several ways. They chose a pig valve over the more commonly used cow valve because of the size difference. They used only the valve and minimal surrounding natural tissue. And they had to abandon the approach of transporting the valve through the heart with a catheter, instead relying on a "lasso" to hold the valve securely to the balloon that carried the valve into place.

"Many changes in plans occur when you do a procedure for the first time," said Jeffrey A. Feinstein, MD, MPH, assistant professor of pediatrics (cardiology) and one of the cardiologists who performed the procedure. "We're lucky we have a flexible team that works well together."

Feinstein, who is also associate director of the Pediatric and Congenital Cardiac Catheterization Laboratory at LPCH, predicts the hospital will receive



**JEFFERY A. FEINSTEIN, MD, MPH,**  
Director of Pulmonary Vascular  
Diseases at LPCH

more referrals of patients who need a new valve but don't have many other options.

"We make it look easy, but physicians aren't going to go out and do this right away," he said. "We're a long way from this being standard procedure."

Stanton B. Perry, MD, clinical associate professor of pediatrics (cardiology) and director of the pediatric catheterization lab, collaborated with Feinstein on the procedure. V. Mohan Reddy, MD, associate professor of surgery and chief of pediatric cardiothoracic surgery, provided the surgical expertise required to fashion the stent-valve combination.

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[heartcenter.lpch.org](http://heartcenter.lpch.org) or call  
(866) 213-2727.

## LUCILE PACKARD CHILDREN'S HOSPITAL IS FIRST CALIFORNIA PEDIATRIC HOSPITAL TO PERFORM BARIATRIC SURGERY

### HOSPITAL HAS ESTABLISHED STRICT ELIGIBILITY REQUIREMENTS FOR ADOLESCENTS SEEKING THE STOMACH-REDUCING OPERATION



**CRAIG ALBANESE, MD,**  
Surgical Director of LPCH Center  
for Healthy Weight, performing  
surgery.

In November, LPCH surgeons performed the first bariatric surgery at a California children's hospital. Until now, adolescents in California who were eligible for bariatric surgery turned to surgeons at adult hospitals. But physicians at the LPCH Center for Healthy Weight believe this surgery of last resort should be available in a pediatric context.

"It's paramount that adolescent specialists care for these children in kid-centric facilities," said Craig Albanese, MD, who is chief of pediatric surgery and surgical director for the Lucile Packard Center for Healthy Weight as well as a professor of surgery at the Stanford University School of Medicine. "This is not a quick-fix operation. This is a tool that helps people achieve a healthier lifestyle, and it requires an appropriate support system for the patient and the family."

On Nov. 9, Albanese and John Morton, MD, assistant professor of surgery at Stanford and director of its adult bariatric surgery program,

performed the surgery, called a Roux-en-Y gastric bypass. The procedure, which reduces the patient's stomach to the size of a walnut, will be done only on a very selective basis on a limited number of patients who meet stringent criteria, said Lawrence Hammer, MD, director of the LPCH Center for Healthy Weight and professor of pediatrics.

Albanese explained, "We're only going to operate on the most severely ill of the severely obese adolescents."

Harvey Cohen, MD, PhD, LPCH chief of staff and chair of the Department of Pediatrics at the School of Medicine, said bariatric surgery is one piece of LPCH's comprehensive program for healthy weight. "We are committed to helping children and families deal with what we consider one of the biggest epidemics in pediatrics today—the epidemic of obesity."

One-half to three-quarters of all obese adolescents will carry their obesity into adulthood, increasing their risks of developing serious or life-threatening conditions. The risk increases to 80 percent if one parent is also obese. But some obese adolescents already suffer from serious obesity-related illnesses. These teens may be eligible for bariatric surgery.

Before instituting an adolescent bariatric surgery program, LPCH established clear guidelines for patient eligibility. Drs. Albanese and Hammer co-authored a paper, published in *Pediatrics* last July, outlining appropriate steps for deciding which severely obese adolescents would be good candidates for surgery.

At LPCH, teens seeking bariatric surgery must have a body mass index of more than 40. The teen must also suffer from at least one of three severe obesity-related illnesses: type-2 diabetes, obstructive sleep apnea or pseudotumor cerebri.

At age 18, Albanese's patient weighed 270 pounds, had a BMI of 44 and had

struggled with her weight since kindergarten. "I have been through every weight-loss program you can name," she said. She suffered from the headaches and blurred vision associated with pseudotumor cerebri, as well as back and knee problems and restricted breathing brought on by her weight. She's also at high risk of developing type-2 diabetes—a disease her mother has.

Her mother wants a healthy adulthood for her child. "I've been obese all my life," she said. "I have tremendous health problems. I don't want this life for her."

In addition to suffering from physical ailments due to obesity, bariatric surgery candidates must have completed 90 percent of their growth (which can happen as young as age 13 in girls, 15 in boys), have a supportive family and present objective evidence of a failed diet and exercise program. Patients must also demonstrate that they will adhere to strict dietary and exercise guidelines after the surgery. According to Albanese, "If they can't do what we're asking before surgery, then they won't succeed after."

Albanese said his first patient met all these criteria, describing her as a "poster-child" bariatric surgery candidate. "She adhered to the diet regimen we gave her, kept a nutrition record, followed an exercise program, and has a supportive family," he said.

"People are so ignorant when it comes to obesity," said the patient's mother. "Telling my daughter to see a psychiatrist and go on a diet is like telling someone with cancer to put a Band-Aid on it. Obesity is a chronic disease. It's like cancer. It just kills in a different way."

**For more information** about the bariatric surgery program, call Susan Farrales at (650) 736-2114 or visit [bariatricsurgery.lpch.org](http://bariatricsurgery.lpch.org).



# LUCILE PACKARD CHILDREN'S HOSPITAL RANKS NO. 1 IN SAFETY



**PAUL SHAREK, MD**, Chief Clinical Patient Safety Officer at LPCH

LPCH recently received a perfect score on a national survey of 27 patient-safety practices. The score places LPCH ahead of the 26 other children's hospitals that participated in what is known as the Leapfrog survey.

"This score tells us that we're on the right track toward effectively improving and ensuring patient safety," said Paul Sharek, MD, MPH, the hospital's chief clinical patient safety officer and medical director of quality management.

Many hospitals, including LPCH, instituted new patient-safety initiatives after the Institute of Medicine reported

in 1999 that 98,000 Americans die each year from preventable medical errors made in hospitals.

In response to that report, a number of Fortune 500 companies and other large employers formed the Leapfrog Group to survey hospitals and identify the facilities that had instituted certain safety measures. The Leapfrog Group represents more than 34 million Americans and more than \$62 billion in health care expenditures.

The Leapfrog survey has grown to cover more safety procedures and more hospitals each year. The 2004 sample included 858 hospitals. The survey now provides information in an online format that allows health care consumers to compare hospitals the way readers of *Consumer Reports* check out cars.

The 2004 report added a "quality index" that includes 27 safety criteria derived from a report on safe practices in health care published in 2003 by the nonprofit National Quality Forum. It was on this index that LPCH ranked first among the 27 children's hospitals submitting responses to the Leapfrog survey.

The Leapfrog survey marks one of three national safety measures on which LPCH performed extremely well in 2004. In August the hospital got a perfect score on the triennial Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey, which puts a heavy focus on patient safety. Additionally, in a study that compared adverse drug events at multiple children's hospitals nationwide, LPCH had one of the lowest incidence rates—about 80 percent better than the average.

Combined, these results demonstrate that LPCH has successfully integrated presently known patient safety practices, according to Sharek. Still, there's always room for improvement, he said: "The theory is that all errors are ultimately preventable. So if you're not at zero, you're not there yet."

## PROPOSITION 61 PAVES THE WAY FOR HOSPITAL TO GROW

With the approval of Proposition 61 in November's election, Lucile Packard Children's Hospital is eligible for up to \$74 million in state bond funds that will help to address a shortage in pediatric and obstetric beds on campus.

Additionally, the hospital leadership is exploring whether to create expanded pediatric services in San Jose to improve access to pediatric specialty care for the entire metropolitan area.

Prop. 61 will provide \$750 million for capital improvements at 13 children's hospitals across the state. To receive the allotted funds, the hospitals must apply for grants during the next 10 years and must spend the grants on capital improvements—either facilities or equipment—within three years of receiving them.

"We're thrilled that the people of California are so supportive of California's children's hospitals," said Christopher Dawes, president and CEO of Lucile Packard Children's Hospital. "Virtually all children's hospitals have run into capacity problems and many have old buildings that need replacing."

Lucile Packard Children's Hospital is already in the midst of a \$120 million expansion project that will include a new cancer center, 20 more intensive care unit beds and a new MRI center.

According to Dawes, the hospital will likely use the Prop. 61 funds for three priorities: to finish the expansion project now under way; to grow existing heart, neuroscience, surgical and obstetrics programs; and to create additional pediatric services in the greater San Jose area.

**For more information** on LPCH construction plans, visit [construction.lpch.org](http://construction.lpch.org).

## PEDIATRIC WEIGHT CONTROL PROGRAM

Lucile Packard Children's Hospital is committed to helping children achieve and maintain a healthy weight. The hospital recently began a Pediatric Weight Control Program specifically designed for overweight children ages 8-15 and their families. Designed by pediatric physicians with expertise in the treatment of overweight children, the program promotes long-term healthy eating and exercise habits through a six-month-long series of weekly meetings. Over 80% of children and many parents have lost weight while participating in the program. The next session of the program, which is offered in English, is beginning soon. Interested families will be screened for eligibility, and the children must receive medical clearance from their primary care provider. **For more information** call Cindy Zedeck at 650-725-4424.

## CALIFORNIA TO EXPAND MANDATORY NEWBORN GENETIC SCREENING NEXT SUMMER BUT WHAT TO DO IN THE MEANTIME?

All pediatricians are familiar with the “heel-stick” test that has long been mandated in California to test newborns for four categories of genetic disorders: phenylketonuria (PKU), galactosemia, hypothyroidism and sickle cell disease and other hemoglobinopathies.

Starting next August, California newborns' blood will be tested for more than 30 other disorders that can be identified with a tandem mass spectrometer. The change brings California up to the level of testing already required in 30 other states.

Combined, these additional conditions occur in approximately 1 out of every 5,000 births. Each year, about 100 kids will be born in California with these treatable genetic disorders.

But there's a serious risk such cases won't be diagnosed between now and August, when the new law goes into effect, said Greg Enns, MD, assistant professor of pediatrics and director of the Biochemical Genetics Program at Lucile Packard Children's Hospital.

Because most of the newly screened conditions are treatable if caught at birth, but can be deadly or irreversibly harmful if not discovered in time, Enns said, pediatricians and parents should send newborns' blood samples to private labs for additional testing this year.

“Some pediatricians just aren't very concerned because the odds of a child having one of these disorders is so low,” said Enns. “But they should come to our clinic and see these families.”

Working alongside the March of Dimes, Enns lobbied the California Legislature to change the newborn

screening law. “California has been lagging behind other states in expanding newborn screening,” he said. “Having to tell parents, ‘If your child had been born in Hawaii or 29 other states, he'd be alive today’—that's hard.”

One of the most common disorders identified by the expanded screen is called MCAD (medium-chain acyl-CoA dehydrogenase) deficiency. Children with this condition lack an enzyme that breaks down certain fatty acids in their diet. With early diagnosis, these children can be treated and live absolutely normal lives. Without it, they can die suddenly or suffer severe mental and behavioral disabilities.

Having seen the effects of diseases such as MCAD deficiency, Enns recommends that pediatricians send a newborn's blood samples to both the state's screening labs (for the four traditional tests) and private labs that will, for a fee (\$25 to \$100), test the blood for the additional conditions with the tandem mass spectrometer. Many insurance companies cover the expanded testing, but MediCal does not.

Some physicians—trying to do the right thing—have been making dangerous mistakes, said Andrea Gansheimer, RN, BSN, JD, director of the State's Newborn Screening Program Area Service Center at Stanford. They either send newborn blood samples only to the private labs and neglect to get the state-mandated screening to check for the most common genetic disorders, or they don't realize that the state lab isn't doing the expanded screening yet.

“There's a lot of confusion about the testing,” said Gansheimer. “I get calls from physicians every single day.”



**GREG ENNS, MD**, Director of Biochemical Genetics Program at LPCH

Starting next August, pediatricians and parents are likely to experience additional bewilderment as the new testing gets under way. “Some physicians might not have seen these conditions in their lifetime of practice,” said Gansheimer. That's where Stanford and LPCH will play a role.

Stanford's Area Service Center will continue to be the first agency to learn of a positive test result in this region. Every day, the center will receive a report from the state labs listing babies with a presumptive positive result for any of the disorders. The center's staff will then contact the child's pediatrician to explain the results and advise the physician on what type of further testing is needed. If the screening result is confirmed, the center helps coordinate the patient's referral to an appropriate physician.

In addition, LPCH's Biochemical Genetics Lab—which houses two tandem mass spectrometry machines and is the only lab of its type in Northern California—could well play a role in confirming diagnoses of newborns from all around the state. And LPCH physicians will continue to treat kids diagnosed with rare genetic disorders.

“We want to find these kids, diagnose them and take care of them,” said Enns. “That's where our expertise lies, and that's what we do.”

**For more information** visit [genetics.lpch.org](http://genetics.lpch.org) or call (650) 736-7642.

### WHERE TO OBTAIN EXPANDED TESTING NOW

Information on tests and costs can be obtained by contacting the following laboratories directly:

Baylor: 1 (800) 4BAYLOR / [www.bhcs.com/MedicalSpecialties/MetabolicDisease](http://www.bhcs.com/MedicalSpecialties/MetabolicDisease)

Mayo: 1 (800) 533-1710 / [www.mayoreferenceservices.org/mml/mml-sns-intro.asp](http://www.mayoreferenceservices.org/mml/mml-sns-intro.asp)

Pediatric: 1 (866) 463-6436 / [www.pediatriccreening.com](http://www.pediatriccreening.com)



## LPCH OFFERS FIRST-TRIMESTER PRENATAL SCREEN THAT DETECTS 85 PERCENT OF FETUSES WITH DOWN SYNDROME TEST STATISTICALLY COMBINES ULTRASONIC MEASUREMENT OF NUCHAL TRANSLUCENCY WITH RESULTS OF TWO BLOOD TESTS

At Lucile Packard Children's Hospital, pregnant women can now be screened in the first trimester for a fair estimate of their fetuses' risk for Down syndrome and some other chromosomal abnormalities.

This test helps women decide early on whether to proceed with an invasive test such as chorionic villus sampling (CVS, in which a catheter samples some material from the placenta) or amniocentesis—procedures that provide definitive results but carry some risk of miscarriage.

Known as the first trimester combined screen, this multifactor test has been proven as accurate at predicting chromosomal abnormalities as the standard multifactor screens commonly used in the second trimester, according to a multi-center American study published in the *New England Journal of Medicine* in 2003.

"It's a test that's here to stay," said Jane Chueh, MD, clinical associate professor of obstetrics and gynecology at Stanford and director of first-trimester screening at LPCH. "Both a positive and a negative result give women helpful information, making the screen a popular option for many prospective moms."

The first-trimester combined screen has been offered at LPCH since January 2004. Demand for the test has been increasing throughout the year, said Chueh, who predicts it will become standard.

"Our goal in prenatal diagnosis is to give women options," she continued. "Part of the appeal of the first-trimester screen is that women are able to act on the results so much earlier."

The screen is done 11 to 14 weeks into the pregnancy. The 12th week is ideal, said Chueh, with results coming in a week later. The screen involves a blood test to determine the levels of two proteins in the mother's blood, combined with a high-resolution ultrasound to

measure the thickness of the nuchal fold, an area at the base of the fetus's neck.

"It's one of the more difficult ultrasound measurements to obtain," Chueh said. To get the correct view of the fetus, the fetus must be in motion. "In fact," she explained, "they need to be jumping away from the membranes. You have to catch them in midair, where you can get a good view of the back of the neck."

Practitioners in the Division of Maternal Fetal Medicine who perform the first-trimester screen have all undergone the rigorous training required for certification—including submitting more than 50 ultrasound images to an auditing agency.

A software program meshes the blood test results together with the nuchal fold measurement to come up with one combined risk measurement to give to the patient, which is expressed as the odds that the fetus will have Down syndrome (trisomy 21) or trisomy 18 (a disorder that leads to death by age 1 in all but a few cases).

Based solely on her age, a 35-year old woman would typically start out with a 1 in 134 chance of having a child with a chromosomal abnormality. After the test is completed, those odds might go up to as high as 1 in 10—indicating that she's more likely to be carrying a fetus with a congenital defect. Or they might go down to 1 in 500 or even 1 in 2000—which would be comforting, but no guarantee. Several studies have found that the screen detects about 85 percent of Down syndrome and trisomy 18 fetuses.

Currently, the State of California pays for a blood test between 15 and 20 weeks into the pregnancy. If that test is positive, the state will also pay for amniocentesis, but results don't arrive until women are into their 19th to 23rd week of pregnancy—worryingly close to the third trimester, when termination is no longer an option.



**JANE CHUEH, MD**, Director of First-trimester Screening at LPCH

Chueh says that the first trimester screen picks up many cases of trisomies that previously would not be detected until the late second trimester. And if the screen is positive, there's time for the mother to get CVS in weeks 13 to 14 or amniocentesis after week 15, giving her a definitive result by week 15 to 17.

**"This is a test that's here to stay. Both a positive and a negative result give women helpful information."**

But most of the women screened get a result that reduces their originally predicted risk. "One of the real benefits of this test is that so many women are reassured because their risks decline afterward," said Chueh.

**For more information** about the first trimester combined screen, contact the Charles B. and Ann L. Johnson Center for Pregnancy and Newborn Services at (650) 498-4069.

## RESEARCHERS PURSUE TREATMENT OF PEANUT AND OTHER FOOD ALLERGIES ON TWO FRONTS

### STUDIES OFFER HOPE TO MILLIONS



**RICHARD MOSS, MD,**  
Chief of Pediatric Pulmonary  
Medicine at LPCH

Researchers at Lucile Packard Children's Hospital are making progress on two treatments for allergies to peanuts and other foods. One is an anti-antibody, the other a vaccine. Both hold great promise for the million and a half people with potentially deadly allergies.

"Peanut allergy is a serious life-threatening allergy that puts a great deal of fear into people," said Richard Moss, MD, professor of pediatrics and chief of pediatric pulmonary medicine at LPCH. "It's often persistent over a long time, and there's no treatment. These studies offer some hope of preventing allergy attacks if peanut is accidentally ingested."

At its most severe, an allergic reaction to peanuts can lead to anaphylactic shock with fatal cardiac arrest or airway swelling. About 100 people, mostly children, die annually because they accidentally ingest allergenic foods. Peanuts are the most common culprit.

A research team led by Moss is currently seeking volunteers to study whether Xolair—a medication already approved to treat asthma in patients older than 12 years of age—will help allergic patients tolerate greater amounts of peanuts.

Xolair is an anti-antibody that reduces the level of the primary antibody—called IgE—involved in peanut allergy. When peanut protein enters the body, IgE triggers the cascade of histamine and other chemicals involved in an

anaphylactic reaction. By lowering IgE levels, Xolair might increase the amount of peanut a patient can tolerate—a connection supported by a study published last year, in which a drug similar to Xolair significantly increased 84 patients' peanut tolerance.

In Moss' study, patients between 6 and 75 years of age with peanut allergy will be tested to determine how much peanut they can tolerate before and after treatment with Xolair or placebo. Small amounts of peanuts will be given orally with close monitoring in a safe setting, and any allergic reaction will be treated immediately. The study will enroll about 150 patients at 20 sites in the United States, Canada and Europe. Genentech, the company that makes Xolair, funds the research.

In separate research, vaccines have reduced or eliminated reactions to peanuts, milk and wheat in dogs. The findings were published in *Allergy* in November by Dale Umetsu, then professor of pediatrics at Stanford and chief of the division of allergy and immunology at LPCH.

Umetsu studied nine dogs, four allergic to peanuts and five to both milk and wheat. Ten weeks after the dogs were vaccinated for the relevant allergenic foods, it took significantly greater amounts of those foods to generate the telltale allergic bump in standard skin tests.

In addition, all four peanut-allergic dogs could safely eat much larger quantities of ground peanut three months after vaccination. On average, they went from tolerating about one peanut to tolerating more than 37 peanuts.

Similarly, when milk-allergic dogs were fed 0.2 grams of milk two to four months after vaccination, they exhibited a 100 percent reduction in vomiting and a 60 percent reduction in diarrhea compared to their reactions before vaccination. The results for every test were statistically significant.

The vaccines contain a dead bacterium—heat-killed *Listeria monocytogenes* or HKL—mixed with peanuts, milk or wheat. "We thought that if we mimicked infection using HKL, we might engage the immune system in ways it was designed for, and in this way protect against allergy," Umetsu said.

This idea is consistent with the so-called hygiene hypothesis, which attributes the recent escalation in all types of allergies to the excessive cleanliness of modern life. This theory posits infections as critical in protecting against allergies. Vaccines containing HKL and the relevant allergen have been shown to prevent allergic reactions in mice with asthma (by Umetsu) and with peanut allergies (by other researchers). The *Allergy* paper takes the approach to a larger mammal—an important step, because dogs are closer to humans on the mammalian family tree.

"These studies offer some hope of preventing allergy attacks if peanut is accidentally ingested."

Umetsu cautions that the vaccine is not yet ready for human testing. "We still have to do additional studies to see if the vaccine causes unforeseen problems in animals," he said. But he has great hopes the research could result in an effective food allergy treatment.

**For more information** about the Xolair study or to volunteer for that study, please contact Lisa Hoyte at (650) 723-5227 or email [choyte@stanford.edu](mailto:choyte@stanford.edu). For information on the allergy clinic at LPCH, visit [allergyasthmaimmunology.lpch.org](http://allergyasthmaimmunology.lpch.org).



# PUBLICATIONS AND FACULTY UPDATES

## FACULTY UPDATE



**ANN ARVIN, MD**, Lucile Salter Packard Professor of Pediatrics and Chief of Pediatric Infectious Disease at Lucile Packard Children's Hospital, was appointed to the National Academy of Sciences Board of Life Sciences, which provides advice to government and the scientific community on the biological sciences and their impact on society. The board's work encompasses all life sciences from molecular genetics to biodiversity.



**MARLENE RABINOVITCH, MD**, the Dwight and Vera Dunlevie Professor in pediatric cardiology and Director of Cardiovascular Research at the Vera Moulton Wall Center for Pulmonary Vascular Disease, received the 2004 American Heart Association Basic Science Research Award. The award recognizes individuals who have made outstanding contributions to cardiovascular science. Much of her research focuses on the regulation of genes associated with vascular development and vascular pathology. Rabinovitch, who came to Stanford in 2002, is past chair of the scientific advisory committee of the Canadian Institutes of Health, and associate editor of *Circulation Research*. She received the award at the AHA annual scientific meeting in November.



**DAVID K. STEVENSON, MD**, the Harold K. Faber Professor of Pediatrics and of obstetrics and gynecology at the School of Medicine and Chief of Neonatology at LPCH, was awarded the Neonatal Education Award in Perinatal Pediatrics by the American Academy of Pediatrics. Stevenson, who is senior associate dean for academic affairs at the medical center and an accomplished independent investigator in neonatal biology, was recognized for his outstanding contributions in neonatal-perinatal medicine.



**GREGORY HAMMER, MD**, was promoted to professor of anesthesia and, by courtesy, of pediatrics, effective Oct. 1. He also continues to serve as the Associate Director of the Pediatric Intensive Care Unit at LPCH. Hammer's primary research interest is pediatric pharmacology, and he has published extensively on the effects of vasoactive and anesthetic drugs in infants and children. Hammer also serves on the editorial board of *Pediatric Anesthesia*, and has lectured on pediatric pharmacology at numerous national and international meetings. He is the principal investigator on a \$4.3 million award from the National Institutes of Health to test whether a drug commonly used to treat hypertension in infants and children is safe and effective.

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# LUCILE PACKARD CHILDREN'S HOSPITAL

## IMPORTANT CONTACT INFORMATION

### Physician Hotline for Referral & Consultation

24-hour, immediate referral and consultation

Tel. (800) 995-5724

Fax. (650) 843-0136

referral@stanfordmed.org

### 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

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## CME COURSES

### Pediatric Clinical Update

March 19, 2005

Doubletree Hotel, Modesto

### Pre-Conference: Practical Childhood Obesity Management

July 7, 2005

Frances C. Arrillaga Alumni Center, Stanford

### Thirteenth Annual Pediatric Update

July 8–9, 2005

Frances C. Arrillaga Alumni Center, Stanford

### For More Information

(650) 497-8554 or visit [cme.lpch.org](http://cme.lpch.org)

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