



QUARTERLY NEXUS

BACK TO SCHOOL HEALTH ISSUES

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Numerous health issues are identified when children go back to school.

This issue looks at some of these health issues.

Excellence and Innovation for
All Children's Well-Being



ASTHMA IN SCHOOLS

BY PATTY DAVIS

Omaha Public Schools has developed and implemented a protocol for their response to life-threatening asthma or systemic allergic reactions (anaphylaxis) to provide quick responses to the growing number of students who have these conditions. Sometimes school personnel are only alerted to the fact that a student has a condition after an attack has occurred at the school. Many students have also gone undiagnosed. Some students who have been diagnosed with asthma or severe allergies do not adhere to the prescribed medical regimen. Sometimes the factors involved in non-adherence may include misunderstanding the need for medications, fear of side effects, dislike of medication, misunderstanding of management plan, lack of guidance for self-management and poor supervision and training.

Based on these concerns Health Services convened an "Asthma Advisory Committee." The primary goal of the committee is to review current practices related to the emergency responses to life-threatening asthma or systemic allergic reactions. After a review of the protocols and practices from school districts across the nation and with input from area physicians and the American Lung

Association, a protocol was developed.

The nursing protocol that was developed is as follows:

1. CALL 911
 2. Summon the school nurse if available. If the school nurse is not available, summon designated trained non-medical staff to implement the protocol.
 3. Check airway patency, breathing, respiratory rate, and pulse.
 4. Administer medications: EpiPen and/or Albuterol per standing orders.
 5. Determine cause as quickly as possible.
 6. Monitor vital signs (pulse, respiration).
 7. Contact student's parent/guardian immediately and physician as soon as possible.
 8. Any individual treated for symptoms with epinephrine at school will be transferred to a medical facility.
- The standing orders for response to life-threatening asthma or anaphylaxis are as follows:
1. Administer an IM EpiPen-



*Activity or Inactivity.
Which category fits youth today?*

Jr for an individual less than 50 pounds or an adult Epi-Pen IM for an individual over 50 pounds, and/or nebulized Albuterol, 0.5cc plus 3cc of saline. If not better, may repeat time two.

2. Administer CPR, if indicated.

The State of Nebraska is working on new laws to help with Epi-Pen placement in schools and also funding of these Epi-Pens.

Source: Omaha Public Schools Health Services

THE BUZZ FROM BRUCE . . .

BY BRUCE BUEHLER



Dr. Bruce Buehler,
Professor and Chair,
UNMC Pediatrics

Health Partnerships with the schools are critical as resources continue to decrease and needs continue to increase. It is clear that the schools are dealing with an ever-changing population of children, including those with autism, prematurity, and behavioral problems. All of these conditions pose a great financial, as well as health, burden for the schools. It is critical that all children, including those with special health care needs, receive the finest education possible and develop the greatest potential possible. It is time for all pediatricians to more closely interact with school administration in the community and at the state level. Schools, by definition, cannot provide all of the services of a surrogate parent, nor can they provide all of the services of a qualified, medical home. I believe pediatricians can partici-

pate in the process of developing school-based services that serve all children throughout their educational years.

I have spent the majority of my career working with children with special health care needs, developmental disabilities, and orthopedic handicaps. I know how much the parents rely on the school system to help them in the day-to-day care. Physicians need to reconsider their participation in educational planning, on an individual basis, in order to help the schools understand the medical limitations or the medical needs that each child may require. Sending a note to the family or giving the family direction may not be enough in the future as the schools are under greater limitations and require more information to make decisions. Over the past five years, I have spent a great deal

of time with individual families and school administrators developing an individual and family-centered educational plan that is appropriate for the child and within the scope of the school's mission. I have been pleasantly surprised by the amount of cooperation I have received and the outcomes of the cooperation between the parents and schools. I believe if we are more active in offering to help parents develop the ideal educational and medical program for their children, we can increase access and decrease confrontational meetings. Although at the present time physicians are not reimbursed for the time spent with the schools, I believe this is our next major campaign – to have reimbursement for support of families through the school which encompasses 21 years of their

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SCHOOL HEALTH AND PEDIATRIC MEDICINE: A TWENTY FIRST CENTURY PARTNERSHIP

EDITORIAL BY AMY LACROIX

I became involved in school health the first day I chose a career in pediatrics. I just didn't realize it until much later. I now understand that school health is an integral part of pediatrics that involves many people on many levels: medical and educational administrators, physicians, nurses, teachers, parents, children, the community at large, and, of course, politicians.

School health includes school physicals and absentee notes, but that is just the tip of the iceberg. In working with schools, I often feel like the Titanic, plowing into waters with an enormous amount of mass underneath that I know little about, and am ill prepared to deal with. Some issues underneath the water these days: school based health centers, school nutrition programs, automated defibrillators in the

schools, asthma management and anaphylaxis, physical education, TB screening, immunization requirement revisions, head lice management, school nursing burdens, special needs services, alternative school programming, and aftercare programs. Every program requires funding and supervision, and every school has a budget.

School health is public health for school-aged children. By working with the schools, more can be accomplished for children and adolescents than we could ever hope to do in our offices on a day-to-day basis. In Nebraska, legislation has been passed recently mandating that *every school* has a plan (and equipment!) to deal with emergency management of asthma and anaphylaxis. In Grand Island, a school health center serves the needs of many teens

that would otherwise have no medical home. In Omaha, school staff members are being trained to use automated defibrillators in all middle and high schools. These are amazing steps in protecting and promoting the health of our children in their schools.

Consider partnering with local schools and advocating for them in any way that you can. Many resources are available to help guide you in your school health endeavors through the American Academy of Pediatrics, the American Cancer Society, the Ambulatory Pediatric Association, the Society for Adolescent Medicine, and the American School Health Association. Evidence is clear that healthy children have more success in school, and educated children are more successful in life.

THE PREPARTICIPATION PHYSICAL EXAMINATION

BY KODY MOFFATT, M.D.

As the fall sports season returns, area pediatricians are once again called upon to determine the adolescent athlete's suitability for competition. This seasonal event has the potential to be maligned simply from the sheer volume of patients seen and often mundane nature of the Preparticipation Physical Examination (PPE); however, the PPE has the potential to be a valuable tool in the delivery of adolescent health care and a safety net for the athlete.

The PPE can be a valuable tool in adolescent health care.

The objectives of the PPE are simple. First the identification of conditions which predispose athletes to disabling or life-threatening events or serious nondisabling injuries is paramount. Secondary objectives include an evaluation of general health and fitness level for specific sports, as well as an opportunity to counsel adolescents and parents on health-related issues.

Much of what has come to be expected in the PPE has evolved without supporting evidence. The current standard of care includes an annual evaluation performed at a reasonable time before the start of the season. The emphasis is on a history and physical exam which focuses on some very specific risk factors. It has been shown that approximately 75% of

problems in athletes can be identified by history.^{3,4} Historical questions are designed to uncover serious conditions such as hypertrophic cardiomyopathy, the long QT syndrome, and significant traumatic brain injury.

Published by the American Academy of Pediatrics and four other major medical societies, *The Preparticipation Physical Examination (2nd edition)*¹ has become the gold-standard for the administration of the PPE. It includes a list of focused questions to be asked as well as easy to use forms for the office. History should be obtained from the athlete and parent. One study found 39% of histories obtained from teen-age athletes agreed with the parental history.⁴

The general medical exam is augmented with a "two-minute musculoskeletal screening exam" which does not require a high level of expertise in musculoskeletal medicine.^{1,2} Positive findings in the general medical exam or musculoskeletal screening exam require diagnostic follow-up.

Positive findings in the PPE require diagnostic follow up.

Historically "screening labs" have been performed during the PPE. These have fallen out of favor and are not recommended by the relevant medical societies unless they are part of a work-

up for something uncovered during the H & P. Specifically, Tanner Staging, routine urinalysis, blood work, electrocardiograms, chest radiographs, and echocardiograms are no longer considered part of the PPE.

Anyone who treats school age children should be aware of the PPE.

The AAP and the American Academy of Orthopedic Surgeons have also published a text² which is a valuable resource to the pediatrician who wishes to have a more valuable resource on their shelf and should be considered for anyone who treats young athletes.

References:

¹American Academy of Family Physicians, et al; Preparticipation Physical Evaluation – 2nd ed. McGraw-Hill Companies, Minneapolis, MN; 1997

²Anderson SJ, et al (Eds.); Care of the young athlete. American Academy of Orthopedic Surgeons and American Academy of Pediatrics, Elk Grove Village, IL; 2000

³Goldberg B, et al: Preparticipation sports assessment: an objective evaluation. *Pediatrics* 1980;66(5):736-745

⁴Risser WL, et al: Frequency of Preparticipation sports examinations in secondary school athletes: are the University Interscholastic League guidelines appropriate? *Tex Med* 1985;81(7):35-39

BUZZ CONTINUED

life. By definition, pediatricians are advocates and we need to advocate for the schools, parents, and children to optimize each child's quality of life.

Finally, each year I have the

privilege of attending five or six high school graduations of children with special needs that I have worked with since birth. I have seen their growth and development far beyond any ini-

tial predictions. I cannot think of a greater reward for any medical professional than to see your young patient succeed and surpass all expectations.

ADOLESCENT OBESITY IN THE US AND CLOSER TO HOME

BY MAUREEN FITZGERALD, MPA

Did You Know...

In 1999, 13% of children aged 6 to 11 years and 14% of adolescents aged 12 to 19 years in the United States were overweight. This prevalence has nearly tripled for adolescents in the past 2 decades.

Risk factors for heart disease, such as high cholesterol and high blood pressure, occur with increased frequency in overweight children and adolescents compared to children with a healthy weight.

Type 2 diabetes, previously considered an adult disease, has increased dramatically in children and adolescents. Overweight and obesity are closely linked to type 2 Diabetes.

Overweight adolescents have a 70% chance of becoming overweight or obese adults. This increases to 80% if one or more parent is overweight or obese. Overweight or obese adults are at risk for a number of health problems including heart disease, type 2 diabetes, high blood pressure, and some forms of cancer.

The most immediate consequence of overweight as perceived by the children themselves is social discrimination. This is associated with poor self-esteem and depression.

Source: *The Surgeon General's Call To Action To Prevent and Decrease Overweight and Obesity*: http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_adolescents.htm

In August, CityMatCH at UNMC and NACCHO (The National Association of County and City Health Officials) sponsored a national teleconference on *"The Obesity Epidemic: Reversing the Trend among America's Youth."** Speakers, including Dr. Barry M. Popkin, Professor of Nutrition, School of Public Health, University of North Carolina, discussed adolescent obesity.

Visit any US shopping mall or high school and look around: the evidence of overweight adolescents is glaring. An article recently published in JAMA reported the percentage of boys aged 6-11 classified as overweight (*with overweight defined as having a Body Mass Index for age at the 95th percentile or higher*) rose from 4.3% in 1971-74 to 16% in 1999-2000. The percentage of girls in this category rose from 3.6% to 14.5%. What changes have brought the next generation to this point?

Portion sizes, the number of eating occasions per day and the location of eating have changed. Large portions are the norm for many Americans. More people eat out frequently and more calories from high carbohydrate snacks and sugary sodas are consumed by all age groups than ever before.

Conversely, significant decreases in physical activity have also occurred. Trends in walking, biking, exercise and physical leisure time activities for adolescents continue their downward spiral. As Dr. Popkin said, *"Inactivity is high and physical activity low among US adolescents, especially minority adolescents."* The switch from playing tag, sandlot baseball, and kickball after school, to sedentary patterns of computer and television use is taking a toll on youth.

A recent CDC-sponsored sur-

vey of children aged 9-13 years and their parents found that 61% do not participate in any organized physical activity during after-school hours or on weekends, and 23% do not engage in free-time physical activity during those hours. The percentage of US students attending daily physical education classes decreased from 42% in 1991 to 32% in 2001.

How prevalent is the problem of obesity in local children? To Sharon Moran, R.N., Director of Nursing Services for OPS (Omaha Public Schools), the situation is similar to national trends. Increasing focus on academic achievement, standardized test scores and academic requirements have the unfortunate effect of causing teachers to neglect student needs for physical activity. Moran believes increased physical activity is linked to better educational outcomes. Teachers should be encouraged to offer playground activity in the morning and afternoon for younger children and after lunch for fifth and sixth graders.

School pop and snack food vending machines, student stores, snack bars and candy fundraisers offer negative competition for more healthy lunchroom fare. Financial benefits from vending contracts and student fundraisers are indisputable; the impact on children already at risk for being overweight is equally clear: when students have the option of vending machine choices along with the National School Lunch Program (NSLP), they are less likely to eat healthier vegetable, fruit, or juice options than students who are only offered the NSLP. Nationally, some schools are reviewing fundraising practices that involve the selling of sweets to schoolchildren.

At OPS, Moran believes developing effective plans to address obesity will take time. Nutrition staff strives to keep fat and calories down in lunch menu choices, and to offer lower calorie and fat alternatives, but providing more nutritionally sound lunches with fresh fruit options is a needed step. OPS previously implemented an obesity awareness campaign, contacting parents by mail when school physicals indicated obesity. Outraged parents went to the school board indignant about 'harassment' and the letter campaign was ended.

On a positive note, Moran believes that adolescent obesity trends can change through the joint efforts of parents and schools. When parents promote healthy eating and exercise habits at home, and when schools stress the importance of good health and lifestyle choices in science, physical education and health classes, change may be seen. Dr. Barry Popkin suggested a number of changes including changes in the physical environment that encourage walking, special sales taxes, or so-called "sin taxes" on soft drinks and snacking foods, reducing vending machine accessibility in schools, changes in food labeling, additions to training in medicine, nursing and dentistry that describe healthful diet and activity patterns, and a whole host of potential changes in school lunch menus and other food options at school. With so many contributing factors leading to adolescent obesity, one thing is clear: it will take changes in many areas of life to slow and reverse this alarming trend.

*For more information about the "Emerging Issues in MCH" audioconference series held the third Thursday of each month at 2 p.m. Central, visit the CityMatCH website at www.citymatch.org

STUDENT WELLNESS CENTER MEETS NEEDS OF CHANGING POPULATIONS

BY MAUREEN FITZGERALD MPA

"Improving young people's access to health services by providing comprehensive, low-cost, convenient physical and mental health care," - is the mission of the Grand Island High School Student Wellness Center, the only school-based health center in Nebraska.

Dr. Karen Higgins, a 1977 UNMC alumna, has played a key roll in the planning, development and ongoing operation of the Grand Island Center. Though managing a busy pediatrics practice, Dr. Higgins makes time for her role as Wellness Center Medical Director.

She describes the Wellness Center as a true community effort championed by citizens, the local high school and hospital. A partner of Dr. Higgins was slated to attend the initial planning meeting in 1994, but fate intervened. A conflict arose; Dr. Higgins stepped in and was in her words, "hooked" from that point forward.

The Center is a joint effort of Saint Francis Medical Center and Foundation and the Grand Island Public School District. Financial and in-kind support from the hospital has been critical to the Center's operation. Matching funds from the Robert Wood Johnson Foundation paved the way and the hospital has been extremely generous through the years.

All labwork and testing are processed through St. Francis Hospital, and the clinic is

staffed with four full-time hospital employees, including an alcohol and drug counselor, mental health provider, nurse practitioner, and a medical assistant/receptionist that provide services for the Center. Dr. Higgins is onsite one day each week and available for phone consultation.

Considering the relative dearth of mental health services in the area, the mental health component represents a great opportunity. Little class time is lost getting to and from counseling appointments with services "right down the hall."

Grand Island, like any number of U.S. cities, has seen an influx of immigrant and undocumented populations in recent years. Many of the children have no regular medical care. Teens are sent to the Center for physicals when they register for school. For those without parents nearby, perhaps living with relatives or friends, this enables them to connect with the health care system. Students can enroll in Kids Connection, (Nebraska's State Child Health Insurance Program) and Medicaid on site. The Center also offers required immunizations.

Receiving medical care in a setting that is convenient and safe is important for those without a medical home. Teens perceive visiting the Center as a "normal" and acceptable option. The Center acts as a clear-

inghouse, making referrals to local physicians. Also, after students visit the Center, the family physician (if there is one) is faxed an amendment for the student's chart.

Parents are assured their primary role by the Center's requirement that parents sign a waiver if they would like their children to be seen. Also, parents are welcome to come along and can be called when their kids have been seen.

Access to contraceptive services, pregnancy testing, and other reproductive issues was an issue during the planning phase. Currently, the Center does pregnancy and STD tests upon request, but does not provide or promote contraception.

A unique offshoot of the Center has been the development of a new medical/academic track at the high school. Students can take tailored medical courses and receive credit hours applicable to majors in nursing, medical technology, dentistry and other allied health fields. A classroom complete with dummies for students to practice on, dental chairs and more have been adapted for these courses. This medical track serves as a model for other high schools to follow.

For more information about the Grand Island High School Wellness Center, contact Sue Beedy at (308) 384-2265 <http://www.healthinschools.org/sbhcs/survey02.htm>

A School Based Health Center is located within a school building; providing comprehensive primary and mental health care and interrelations of family, school and community.

AWARDS

Maureen Fitzgerald, CityMatCH received the Silver 'U' Award for August 2003.

Tom Poulton, M.D., has been appointed to a 26-member task force to study issues surrounding the recent increase in violet child deaths in Nebraska.

Jose Romero, M.D., received the "Latino on the Move" award for his contribution to the community.

This was given by the City of Omaha.

Jon Vanderhoof, M.D. was named among "America's Top Doctors" in the latest edition of their national guide of top doctors.



UNIVERSITY OF
Nebraska
 Medical Center

PRESENTATIONS

- Amin, Z.** Periventricular Closure of Ventricular Septal Defects. Presented at Children's Memorial Hospital in Chicago, IL.
- Amin Z.** Closure of Perimembranous Ventricular Septal Defect without Cardiopulmonary Bypass. Presented at the 83rd Annual meeting of the American Association for Thoracic Surgery. Boston, MA.
- Amin Z.** Preliminary Results of Genesis Stents in Native and Postoperative Pediatric Congenital Cardiac Lesions: A Multi-Institutional Study and Closure of the Coronary Artery Fistula with the Amplatzer Duct Occluder: Preliminary Results from the Registry Group. Presented at the Society for Cardiac Angiography and Interventions 26th Annual Scientific Sessions
- Amin, Z.** A New Stented Self-expanding Valve in the Pulmonary Position and Extending the Limits of Amplatzer Septal Defect Occluder: Closure of Atrial Septal Defects Beyond 40 mm Diameter. Invited speaker: 6th International Workshop Catheter Interventions in Congenital Heart Disease and Other Non-coronary Procedures Frankfurt, Germany.
- Dave, B.J.;** Hess, M.D.; Pickering, D.L.; Weisenburger, D.D.; Chan, W.C.; **Sanger, W.G.** Mantle Cell Lymphoma, the Presence of t(11;14)(q13;q32) and Secondary Chromosomal Changes: A Combined Cytogenetic and FISH Analyses. Presented at the American Association of Cancer Research Toronto, Ontario, Canada.
- Dave, B.J.;** Hess, M.M.; Pickering, D.L.; Weisenburger, D.D.; Chan, W.C.; **Sanger, W.G.** Cytogenetic and M-FISH Studies in Pediatric and Adult Hodgkin's Disease. Presented at the 1st International Symposium on Childhood and Adolescent Non-Hodgkin's Lymphoma. New York, NY.
- Dave, B.J.;** Jain, S.; Hess, M.M.; Weisenburger, D.D.; Sanger, W.G. The t(2;5) and Secondary Chromosome Anomalies in Pediatric and Young Adult Anaplastic Large Cell Lymphoma. Presented at the 1st International Symposium on Childhood and Adolescent Non-Hodgkin's Lymphoma. New York, NY.
- Fu, K.; Palanisamy, N.; **Sanger, W.G.;** Chan, W.C.; Greiner, T.C.; Aoun, P.; Chaganti, R.S.K.; Weisenburger, D.D. Recurrent Genomic Alterations in Splenic Marginal Zone B-cell Lymphoma. United States & Canadian Academy of Pathology Annual Meeting, Washington, D.C.
- Hausman, M.; Higgins, C.; Wiggins, M.; **Dave, B.J.;** **Sanger, W.G.** Is Peripheral Blood an Acceptable Tissue for Molecular Cytogenetic Monitoring for CML? Presented at the 28th Annual AGT Meeting, Atlanta, GA.
- Bridge, J.** Genetics in the Diagnostic Work-up of Bone and Soft Tissue Tumors: Select Case Presentations. Presented as a Department of Pathology Seminar, Mayo Clinic, Rochester, Minnesota.
- Bridge, J.** Supernumerary Ring Chromosomes in Pleomorphic Hyalinizing Angiectatic Tumor: A Feature of Potential Diagnostic Utility. Presented at the United States and Canadian Academy of Pathology, Washington, DC.
- Bridge, J.** Fusion of ALK to the Ran-Binding Protein 2 (RanBP2) Gene in Inflammatory Myofibroblastic Tumor and a Special Course – An Introductory Molecular Pathology Course. Presented at the United States and Canadian Academy of Pathology, Washington DC.
- Kanev, I.; Zaleski, D.; **Dave, B.J.;** Sanger, W.G. Larger Stalks and Satellites of Chromosome 21 in Patients with Down Syndrome. Presented at the 28th Annual AGT Meeting, Atlanta, GA.
- Kugler, J.D.** Ask the Experts: Pediatric Electrophysiology & Pacing; Catheter Intervention for Atrial and Ventricular Tachycardia. Presented at the 39th Annual Meeting of the Japanese Society for Pediatric Cardiology and Cardiac Surgery, Kobe City, Japan.
- Kugler, J.D.** Current Status of Pediatric Ablation in USA. The Boston Scientific Japan Pediatric Arrhythmia Lecture. Kobe City, Japan.
- Kugler, J.D.** Implantable Loop Recorders: Implantable Cardio-Defibrillators. Presented at the Tokyo Women's Medical College, Tokyo, Japan.
- Kugler, J.D.** Pacemaker Management of Children with Pacemakers: A Potpourri of Pediatric Pacing. Presented for the Japanese Pediatric Electrophysiology Society. Kobe City, Japan.
- Sammut, P.M.** Cystic Fibrosis in 2003. Presented to the Nebraska Chapter of Pediatric Nurses, Omaha, Nebraska.
- Poulton, T.J.** Occupational Health Issues in Clowning and Clowning for Children with Life-Threatening Illness. Presented at the Annual Meeting of the World Clown Association. Jacksonville, Florida.
- Sanger, W.G.** Anaplastic Large Cell Lymphoma and Chromosome Abnormalities in ALCL and Childhood Non-Hodgkin's Lymphoma. Presented at the 1st International Symposium on Childhood and Adolescent Non-Hodgkin's Lymphoma. New York, NY.
- Sanger, W.G.** Childhood and Adolescents Burkitt/Burkitt-Like/Diffuse Large B-Cell Lymphoma CCG & 5961 and General Cytogenetic Studies for COG Lymphoma Protocols. Presented at the Children Cancer Group Meeting, Atlanta, GA.
- Taggart, R.T.; Kelley, P.M.; Cohn, E.S.; Kimberling, W.J.; **Sanger, W.G.;** Nelson, M.; Kenyon, J.; Smith, S.D. Molecular Genetic Analysis of Connexin 26 Heterozygotes for Variation within the GJB2-GJB6 Region. Presented at the Association for Research in Otolaryngology, Dayton Beach, FL.
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HIPAA HINTS

HIPAA, the "Health Insurance Portability and Accountability Act of 1996," provides Federal protection of patient health information. The following HIPAA Q & A discusses de-identified health information, which is not subject to HIPAA regulations.

Question: I know de-identified health information is not subject to HIPAA regulations. What is de-identified information?

Answer: The HIPAA Privacy Rule permits us to de-identify protected health information (PHI) so that such information may be used and disclosed freely, without being subject to HIPAA's restrictions. De-identified information contains no data elements that relate to a specific individual. In order to de-identify PHI, the following 18 individual identifiers **must** be removed:

1. Name
2. Geographic subdivisions smaller than a state
3. All elements of dates (except year) for dates related to an individual & ages over 89
4. Telephone numbers
5. Fax numbers
6. E-mail addresses
7. Social security numbers
8. Medical record numbers
9. Full face photographic images and any comparable images
10. Account numbers
11. Certificate/license numbers
12. Vehicle identifiers and serial numbers, including license plate numbers
13. Device identifiers and serial numbers
14. Web Universal Resource Locators (URLs)
15. Internet Protocol (IP) address numbers
16. Biometric identifiers, including finger and voice prints
17. Health plan beneficiary numbers
18. Any other unique identifying number, characteristic or code (includes prescription numbers), except as permitted by re-identification provisions

Question: Can I download any information (files, documents, programs, etc...) from the Internet?

Answer: Yes, but in order to ensure availability of network resources, including the PHI we are responsible for keeping secure, it is important to use caution when downloading information from the Internet. Only download information from trusted sources and ensure virus protection is active with a current updated release.