CHAPTER NEWS

Newsletter

We are excited to announce that we have started a chapter newsletter. We would like to keep you informed and updated with chapter news and events. The newsletter will go out electronically on a quarterly basis. Please let us know if there are topics you would like to learn about, or information you would like communicated.

New Web Site

We recently launched our new chapter website: https://utahnapnap.enpnetwork.com/

If you have not received an invitation to sign up for our new site, please let us know and we will make sure an invitation is sent out to you. We want to our chapter members to have a way to stay connected to chapter events as well as each other. We will be posting announcements, newsletters, and chapter information on this site. You will be seeing emails come from the ENP Network, this is the company managing our website.

UPCOMING EVENTS & ANNOUNCEMENTS

Fall CE Dinner

Date: Tuesday, November 12
Time: 6:30 p.m.
Location: Market Street Grill
2985 E. Cottonwood Parkway
SLC, UT 84121
Cost: $10 members/ $20 non-members
An electronic invitation has been sent out. Please let us know if you have not received it.

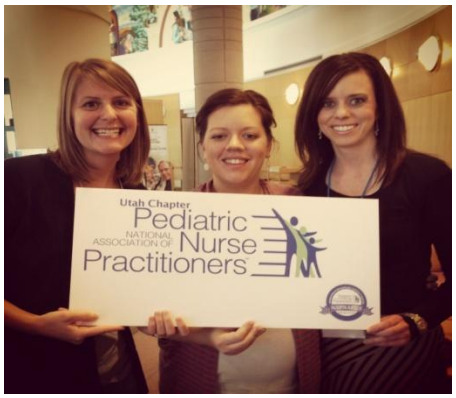
National NAPNAP Conference

Dates: March 11-14, 2014
Location: Boston, MA
Registration is open:
http://www.napnap.org/Events/AnnualConference.aspx

17TH ANNUAL PEDIATRIC CONFERENCE

The Utah Chapter if NAPNAP held its 17th Annual Pediatric Conference in September at Shriner's Hospital in Salt Lake City, UT. The annual conference provides an opportunity to receive continuing education, stay updated on current pediatric topics, meet local vendors, and connect with friends and colleagues.

The conference committee spent the last year planning the annual conference. They use your feedback each year to schedule speakers on topics you request as well as seeking vendors you would like to hear from. They were excited to announce we are fully electronic for the conference; speaker presentations were provided to each attendee on a flash drive.



We had the pleasure of hearing from a variety of speakers from an array of specialties and backgrounds. We heard from our NP colleagues as well as physicians, RN's, and professors. The speakers have done a great job presenting information that is evidenced based and up to date.

We had a fascinating presentation on adolescent brain development by Lesa Ellis, PhD., an adjunct professor at Westminster College. She reviewed new research on brain development which continues into late adolescence, and risk taking behaviors that affect development into adulthood.

Thanks to those who were able to attend the conference this year, it was our largest turnout yet!

Conference Statistics

Attendees: 69	**Contact Hours**: 15
Speakers: 15	**Vendors**: 11

PRESIDENT'S CORNER

Thank you to all of those who came to our annual chapter conference on Sept. 19-20th. I hope that you found it to be educational and applicable to your practice. For those of you who weren't able to attend the conference, I wanted to let you know what the aims of our board are this year:

1. Student outreach
2. Enhance our chapter website
3. Improve communication amongst our chapter members

We have an exciting CE dinner coming up on Nov. 12th at Market Street Grill. You will be receiving an invitation for this soon. We hope that you will be able to attend this event.

Thank you for all that you do, and please don't hesitate to contact me or a member of the board if you have any questions, comments, or concerns.

Sincerely,

Marquelle Wilkinson
Chapter President

snow_skiis@hotmail.com

LEGISLATIVE NEWS

I am happy to continue this year as the legislative chair of the local NAPNAP organization. Over the last 2 years, our efforts have been directed at partnering with the local chapter of AAP (American Academy of Pediatrics). I have represented our group as a liaison to the executive committee of the local AAP chapter. The November meeting will focus on legislative issues, both related to issues regarding care of children and associated legislative issues.

In addition, I will be watching for specific issues related to our practice as nurse practitioners. Throughout the legislative period I will forward bills of interest and concerns, as well as specifics related to the process of lobbying and contacting your specific representatives. I urge each of you to identify your specific representatives in the House and Senate well in advance anticipating that the most effective way of assuring that our needs and ideas are heard and met is by direct contact with those who are on the hill representing us.

I look forward to continuing to represent our group. If you have questions or concerns, please do not ever hesitate to contact me.

Paula Petersen, PNP

MEMBER SPOTLIGHT

Keri Page, DNP

Keri was born and raised in Salt Lake City. After graduating from high school she attended Weber State University and graduated with her BSN in December 2007 with Nursing Departmental Honors. Keri has worked at Primary Children's Hospital (PCH) for 10 years. She started as a patient care tech and then worked as a RN on the Children's Surgical Unit (CSU). While working at PCH, she attended the University of Utah's Pediatric Nurse Practitioner program, graduating May 2011 with her DNP. Keri has been working with the Pediatric Surgery Team since February 2012 and has enjoyed her new position working with general surgery patients. The NP's with the general surgery team have patients on every unit of the hospital, coordinating care, admissions, and discharges. Keri loves that she learns something new every day and that she gets to coordinate care with other specialty services.

Keri played lacrosse for 6 years in high school and college and was a coach at Weber State University. She and her husband met while they were both working at Passages Restaurant. They have been married 8 years and have a 2 year old daughter. They love spending time with their family and friends, travelling, playing outdoors, and waterskiing at Lake Powell and Bear Lake.

Keri is a PALS instructor and a member of the Junior League of Salt Lake where she is the co-medical director of Care Fair. "The Junior League of Salt Lake City, Inc. is a charitable organization of women committed to promoting voluntarism, developing the potential of women, and improving communities through the effective action, education, and leadership of trained volunteers." If you're looking for a way to help the community, contact Keri, as they always need providers for the Care Fair.

SPECIALTY PEARLS: ABDOMINAL PAIN IN THE PEDIATRIC PATIENT

Caralee N. Floisand, CPNP

Abdominal pain is one of the most common complaints in childhood. Usually, the cause is a minor condition such as constipation or a viral illness. The challenge for health care providers is to identify patients with serious, potentially life-threatening conditions that may require surgical intervention or advanced treatment. This article will review basic assessment skills and the most common pediatric abdominal surgical emergencies that need to be referred to a higher level of care.

For most children, the cause of abdominal pain can be identified with a careful history and physical exam. The most important questions to ask are: 1**) pain**-location, duration, intensity, pattern 2) **associated nausea/vomiting**- color, force 3**) bowel movements**- frequency, texture, color 4**) history of recent illness, fever, surgery** and 5) **family history**. By merely asking these five questions, your differential diagnosis can narrowed to a more reasonable list of potential diagnoses.

Your physical exam should be head to toe but focused on the area of pain. It is helpful to ask the patient to point to the place where the pain is and then start your exam exactly opposite of that point. Distraction is very helpful in the toddler and school age child. Try to focus your eyes on the child's face and observe for facial wincing as well as verbal response. Patients with true abdominal pain will guard their abdomen and try and grab your hands.

The most common life-threatening causes of abdominal pain in children are appendicitis, intussusception, malrotation with mid-gut volvulus, incarcerated inguinal hernia and adhesions with intestinal obstruction and trauma.

Appendicitis-The most common cause of an acute surgical abdomen is appendicitis. Patients will complain of periumbilical pain that migrates to the right lower quadrant over 12-24 hours. Nausea, vomiting and diarrhea almost always follow the onset of pain. It is very unusual to have vomiting prior to pain with appendicitis. Not all patients have fever, especially with acute appendicitis. If the appendix has perforated, patients will have generalized peritonitis and diffuse abdominal pain.

Intussusception-Children with intussusception are most commonly between the ages of 2 months and 2 years. Their pain is "colicky"- intermittent but intense and followed by periods of somnolence. There is usually a history of a viral infection in the week preceding the abdominal pain. Patients may report currant jelly stool but not always. They usually do not have a fever but may have emesis. On exam, you may be able to palpate a bulge in the right upper quadrant where the ileo-colic intussusception is located.

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Malrotation with or without midgut volvulus- Any neonate with bilious emesis should have the diagnosis of malrotation with volvulus until proven otherwise. This is truly a life-threatening emergency because lack of blood supply to the gut caused by the volvulus could result in ischemic death to the entire GI system. Over 50 percent of children with malrotation present before one month of age. Any baby with bilious emesis should be referred immediately for an Upper GI series without hesitation.

Incarcerated inguinal hernia- The incidence of inguinal hernia is 0.8% to 4.1% in children. Of the children with an inguinal hernia, 12% to 17% will have an incarceration. Symptoms usually included inconsolable pain, a tender irreducible mass in the groin, vomiting, decrease in bowel movements or bloody stools. About 90% to 95% of incarcerated hernias can be reduced. Occasionally, irreversible damage to the testicular/ovary or bowel does occur. Incarcerated hernias should be quickly referred to a higher level of care if they cannot be reduced in an outpatient setting.

Adhesions with intestinal obstruction- Any child who has had previous abdominal surgery and presents with bilious emesis, abdominal distention and lack of bowel movements should be referred to a higher level of care. Approximately 5% of children will have an adhesive bowel obstruction within 5 years of a major abdominal surgery. Rarely does a child have a congenital adhesive bowel obstruction without prior surgery.

Trauma-Any patient who has sustained trauma to their abdomen and presents with abdominal pain, should be quickly evaluated for injury to solids organs such as the spleen, liver, kidney and bowel. Mechanisms associated with significant injury may include motor vehicle crashes, bicycle and/or pedestrian collisions, falls, and child abuse. Although symptoms of abdominal trauma usually occur immediately, they can be delayed and should be evaluated if the symptoms persist.

Remember, most causes of abdominal pain are self-limited but children who have a history, exam and symptoms concerning for any life-threatening abdominal problem should be promptly evaluated and referred to a higher level of care in a timely manner.

References:

Neuman M, Ruddy RM. Emergent evaluation of the child with acute abdominal pain. UpToDate, 2013.

Ferry, GD. Causes of acute abdominal pain in children and adolescents. UpTo Date , 2013.

BOARD MEMBERS

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