Packard Reduces Antibiotic-Resistant Staph Aureus

Emerging Threat: Hospital and Community Associated MRSA

In 2007, there was a great deal of media coverage about “super bugs,” also known as antibiotic-resistant bacteria. Of these “super bugs,” the one currently causing the most alarm is Methicillin-Resistant Staphylococcus Aureus (MRSA). Concerns about MRSA were raised by the national media when otherwise healthy individuals, including athletes and high school students, were infected. In October, closer to home, several schools in San Mateo reported that both teachers and students had MRSA skin infections.

In a recently published study by the national Centers for Disease Control and Prevention, more than 90,000 Americans get potentially deadly MRSA infections each year. Of those infected, approximately 19,000 die. Some experts believe that MRSA now causes more deaths in the United States annually than AIDS.

Staphylococcus aureus is a bacteria commonly found on the skin, in the nares and on the perineum of healthy people. Approximately 25 to 30 percent of the population is colonized in the nose with staph bacteria. One percent of these staph colonizations

INSIDE FEATURES

A Note From Hugh O’Brodovich, MD 3
Christopher Dawes Research Excellence 4
Quality Data Goes Public 5
Physician Survey Results 6
Community Benefits Putting Health Care Back into Schools 7

Clinical Transformation Program 8
Legislative Update 9
Vascular Access Program 10
Faculty Updates 11
In the future, California may join the growing list of states requiring hospitals to screen high-risk patients, such as those in intensive care units, for MRSA upon admission and to publicly report the HA-MRSA infection rates. A bill was just introduced in the state senate to bring forward this issue.

are with bacteria strains that are resistant to beta-lactam antibiotics such as methicillin, oxacillin, penicillin or amoxicillin.

The first cases of MRSA infection in the United States were reported in the 1960s. Today, it is estimated that 46 out of 1,000 patients have MRSA. There are two types of MRSA. Approximately 15 percent of MRSA infections are community associated (CA-MRSA). The recent outbreaks of CA-MRSA have been linked with biological properties that allow these germs to spread more easily or cause more skin disease. Though the CA-MRSA typically causes skin and soft-tissue infections, often mimicking spider bites, it can also cause bloodstream infections, pneumonia or, rarely, death.

The majority (85 percent) of MRSA infections are from exposure in hospitals and other health care settings. Health care–associated MRSA (HA-MRSA) typically infects patients who have already been weakened with disease or injury. HA-MRSA is more drug resistant and tends to cause more invasive infections.

Because of the increasing rate of MRSA infections, there has been a corresponding increase in pressure for hospitals to do more to ensure patient safety. The Institute for Healthcare Improvement (IHI) recommended five key steps to significantly reduce infections.

- Hand hygiene
- Clean environment
- Active surveillance for MRSA
- Isolation precautions
- Implement best practice bundles
- Prevent catheter-associated bloodstream infections
- Prevent surgical site infections

Packard Children’s saw an 85 percent decrease in HA-MRSA in 2007. We believe this is due to the steps taken to reduce infections in general. Good hand hygiene practices are still the best way to prevent the spread of infections, including these super bugs.

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The federal government, in the form of Medicare reimbursements, is also getting involved. Starting in October, Medicare will reduce payments for the care of individual patients with complications that are viewed as preventable. This includes hospital-associated infections.

At Packard Children’s, we are very proud that, while the community incidence of MRSA has increased, we were able to achieve a dramatic decrease of these potentially deadly infections in 2007. We’d like to thank the entire staff at Packard Children’s for supporting this effort, and in particular the following physicians who helped drive this initiative: Kathleen Gutierrez and Bonnie Maldonado from Infectious Diseases; Bill Rhine (NICU) and David Cornfield (PICU) on the hand hygiene efforts on their units; and Anita Honkanen and Craig Albanese for the surgical infection reduction efforts.
Medical Staff Update

Eye on a Promising Horizon

Last month I joined Lucile Packard Children’s Hospital as the new chair of the Pediatrics Department. But my work with the Pediatrics medical staff had already begun back in November. Many of you were present with me at the departmental retreat on November 2, at which you provided valuable information that will help shape the future of the Department of Pediatrics. Evaluating this input has been a useful orientation to help me gain a detailed picture of the hospital and medical staff experience from several angles: research, education, clinical, community physician and division chief. Since my arrival, Ken Cox, Christy Sandborg and I have begun carefully reviewing the information gleaned at the retreat, to establish the goals and priorities for the next several years at Lucile Packard Children’s Hospital.

To arrive at a hospital that is already so accomplished and widely recognized for its excellence in patient care, safety and quality is a tremendous privilege. To ask where we will go next is exciting, challenging and promising. My intention is to steer the Department of Pediatrics and the medical staff of Packard Children’s toward a horizon of uncompromising excellence for our patients, for our research and for our operation. As we embark on this journey, your continued input will be essential.

Thank you for welcoming me into this exceptional community of outstanding physicians and care providers. I look forward to meeting each of you, and to the bright future that we will build together at Packard Children’s.

Volunteer advisors to Packard Basics include 80 physician leaders and senior administrative leaders from across the United States. Maurice Druzin, MD, and Lori Armstrong, RN, MSN, made Packard Children’s first “outsight visit” to Beth Israel and Children’s Hospital, Boston, to gather new best practices and verify present ones in Pregnancy & Newborn Services. Outsight is strongly associated with high-innovation organizations.

Finally, we have fulfilled requests for overviews on Packard Basics to 42 other organizations, including Harvard Graduate School of Public Health, Child Health Corporation of America, Mayo Clinic (Rochester), MD Anderson Cancer Center, Cincinnati Children’s Hospital, and Children’s Hospital, Boston.

As one mid-career physician leader said about Packard Basics, “I now have a relationship with new people who are leaders. We start way ahead of where we would have started if we hadn’t seen each other and learned together. I see them and know I can go to them, whether they are administrators or physician leaders, because we learned together. We’re building a leadership learning network here.”

To get an invitation to Packard Basics education, please send your name and e-mail to Jane Binger at jbinger@lpch.org or call (650) 736-7137. Our 2008 Leadership Module kicked off January 24 with workshops and follow-up group coaching from February to June.

> COX | Continued from page 1

If you lead a group of physicians or Packard Children’s department, unit or team and haven’t participated in this valuable education yet, I strongly encourage you to join me at Packard Basics education.

In the past, Packard Basics education has included Modules and Skills Labs on leadership, time management and difficult issues/conversations. Of the 100 attendees, 98 percent said they would “recommend the education to peers,” and as many as 92 percent indicated they were “completely to generally successful in completing their goals.” In fact, 37 physician leaders have referred colleagues to Packard Basics education.

Attendance has doubled at the Packard Children’s Leadership Forums that Christopher Dawes and I host. This event provides lectures by nationally known scholars, such as Barry Posner, PhD (The Leadership Challenge), Jerry Jellison, PhD (Managing the Dynamics of Change), and Stanford University’s President John Hennessey. Updates on Packard Children’s goals and key initiatives are also integral to this education.

Christopher Dawes, Susan Flanagan and I have hosted luncheons with physician leaders to learn about each other’s interests. Another Packard Basics event, led by Christopher Dawes, is “Conversations with Our Physicians”—dialogues between 27 physician leaders and small groups of Board members at the past three annual Packard Children’s Board retreats. These will continue in 2008.

Hugh O’Brodovich
Chair of the Department of Pediatrics

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As a leading academic medical center, Lucile Packard Children’s Hospital is engaged in research that advances pediatric and obstetric treatment. This research spans disciplines across medicine and surgery, basic science and clinical trials; reaches beyond our hospital walls to embrace the community as subject; and delivers its positive impact locally and across the world.

In the Pediatrics Department alone, Packard Children’s has more than $20 million in funded research grants with hundreds of studies. Vibrant and diverse, these studies range from the basic science that unlocks the secrets behind, for example, spinal muscular atrophy and cystic fibrosis, and innovative approaches to transferring genes to cure inherited disorders, to the many, many clinical trials we conduct such as the multidisciplinary treatment of obesity, arthritis and diabetes, the implementation of Rapid Response Teams, and the study of improved primary care delivery in the community.

Packard Children’s Pediatrics Department achieves its dramatic results and changed outcomes for patients because of its people. Our physicians and care teams infuse a culture of innovation by fostering discovery, rigorously testing their research, and then bringing their research full circle by evaluating long-term outcomes and effectiveness. This exhaustive commitment to excellence helps Packard Children’s achieve its mission to serve our communities as an internationally recognized hospital that fosters innovation and translates discoveries to provide the very best to children and expectant mothers.

The Children’s Surgical Research program focuses on developmental biology, wound repair and regenerative medicine. Numerous investigators are a part of the program, including the faculty housed in the Hagey Laboratory for Pediatric Regenerative Medicine. This team plays a vital role in the Program in Regenerative Medicine, which links the entire Stanford campus together to promote reparative and replacement strategies for pediatric and adult patients. In the past year, for example, researchers used a small molecule to rescue the second-most common birth defect in the world—cleft palate—in mice before they are born. This research involved faculty from multiple departments and is a terrific example of how researchers at Packard Children’s Hospital are trying to design novel therapies that will revolutionize the care of children in the near future. The Children’s Surgical Research program takes advantage of the incredible depth and breadth of scientific talent in all the schools at Stanford University. For example, faculty members collaborate with scientists in the School of Engineering to develop novel devices to diminish scar formation following wounding. And pediatric cardiac surgeons collaborate with bioengineers, developmental biologists and stem cell biologists to engineer new blood vessels, heart valves and heart muscle.

In obstetrics, Packard Children’s has a longstanding culture of clinical trials that change practice, including innovations in the treatment of preterm labor, the treatment of fetal distress in labor, and the treatment of obstetrical infections, as well as research on new medications for safer and more effective labor induction. Also at Packard Children’s, proteomic and genomic translational studies on infection and preterm labor continue to improve outcomes for mothers and newborns. The Obstetrical Simulation Program at CAPE (Center for Advanced Pediatric and Perinatal Education), in preparing our labor and delivery teams to deal with major and unexpected obstetrical emergencies, has generated national interest and has been presented at major obstetrical educational meetings. This multidisciplinary training with obstetricians, anesthesiologists and nurses is unique in simulation training. For the past five years, Packard’s OB Department has been among the fewer than 10 percent of submissions chosen by the Society for Maternal-Fetal Medicine to deliver oral presentations at its annual conference. As the OB Department continues to develop translational research and basic science research, it also continues to strengthen its research relationship between Packard Children’s and Santa Clara Valley Medical Center. Together, our two institutions deliver nearly 12,000 babies each year.

Packard’s cutting-edge research improves the care delivered not only at Packard Children’s Hospital and its partners, but also at hospitals around the country and the world. This is good news for our patients, and for all patients. The more Packard Children’s can achieve its best, the more our newborns, children and expectant mothers can, too.
Quality Data Goes Public

Lucile Packard Children’s Hospital at Stanford has launched a new Web site that will allow visitors to access a variety of clinical outcomes data about the hospital’s performance. This move toward greater data transparency is another milestone in the hospital’s ongoing campaign to improve and communicate patient safety and quality of care.

“Several studies have shown that data transparency is associated with improved clinical outcomes for patients,” said Paul Sharek, MD, the hospital’s chief clinical patient safety officer. “Our philosophy has always been ‘you can’t improve what you don’t measure.’”

Packard Children’s is the first children’s hospital in California, and one of only a few in the country, to voluntarily report clinical quality outcomes. The Web site (http://quality.lpch.org) currently lists six primary quality measures. These include mortality rates, 31-day readmission rates, catheter-associated bloodstream infection rates in the Pediatric Intensive Care Unit, and the likelihood that pediatric inpatients, obstetric inpatients and clinic patients would recommend Packard Children’s to other families.

Experience with the Dartmouth-Hitchcock Hospital transparency Web site, one of the oldest in the country, has shown patient satisfaction to be the most frequently reviewed outcome by patients. Packard Children’s plans to add more data in the future.

Hospitals routinely rank themselves against regional and national outcomes standards, but they don’t always make such data public. Recently, patient safety organizations like the Leapfrog Group have launched consumer-oriented Web sites that allow consumers and purchasers of health care to make informed decisions about the quality of care offered by individual hospitals. The Joint Commission also considers quality and outcomes rankings when setting standards and accrediting hospitals nationwide.

“This is all about continuing to improve our clinical outcomes as we drive toward high reliability,” said Sharek. “Our first goal is to improve the quality of care we provide. Our second is to empower the community to make educated choices about health care. We are convinced this transparency is good for the community, good for the institution and good for our patients.”
Physician Satisfaction Survey Results

Results from the 2007 Physician Satisfaction Survey have been compiled and are now being reviewed, shared and used to develop a follow-up action plan. The response rate for the 2007 survey was more than double the rate of the previous year, with 34 percent of physicians (74 percent of whom were faculty and 26 percent community physicians) participating.

Packard Children’s overall rating compares favorably to other children’s hospitals and the Council of Teaching Hospitals in the Press Ganey Physician Survey database. The highest scoring areas were in patient care: i.e., quality of care, willingness to recommend the hospital, specialists, and facility appearance and equipment. The lowest scoring areas were in ease of practice: i.e., bed availability, OR operations, administration responsiveness, and outpatient appointment and ancillary service availability.

Our targeted areas for improvement this year will include: laboratory, radiology, Emergency Department, LINKS/IT, hospital administration and clinic appointment availability. Members of the Faculty Practice Organization (FPO), physicians and hospital administrative leaders are working with those areas and will develop the 2008 Physician Survey Action Plan addressing the top three to five priorities. The Quality Improvement Committee (QIC), under the direction of Paul Sharek, MD, will approve and monitor the progress of the action plan throughout FY ’08.

If you have questions or would like more information, please contact Larry Hammer, MD, Ambulatory Care Center medical director at lhammer@lpch.org or Pam Molano, chief administrative officer for the FPO and vice president for physician and ambulatory services, at pmolano@lpch.org.
It’s common to think of Lucile Packard Children’s Hospital’s facility in Palo Alto as the only setting for its services to children, adolescents and pregnant women.

But, more and more, Packard Children’s provides support in communities needing improved health care. Through Packard Children’s Community Partnerships program, the hospital extends itself into neighboring communities to help build the capacity of other organizations to meet the health needs of children and expectant mothers. By providing funding, technical assistance, human resources or educational programs, Packard Children’s improves access to care for children and expectant mothers in East Palo Alto, in school health clinics in San Jose, and in other locations.

An exciting new initiative is the hospital’s five-year partnership with the Lucile Packard Foundation for Children’s Health to provide $2.65 million to expand school health services in the San Jose Unified School District. This gift has allowed the district to hire four nurses to serve four schools full-time, and funds a nurse practitioner based at School Health Clinics of Santa Clara County to support the four nurses and the students at their schools.

The schools—Hoover and Burnett Academy middle schools, and Empire Gardens and Anne Darling elementary schools, all in the central/east part of San Jose—were chosen because they have a high percentage of students living in poverty as well as substantial enrollments of children who do not have access to regular health care; and because they are near School Health Clinics at San Jose High Academy and Washington Elementary School. The additional NP at the clinics provides support to the four nurses in their care plans for children with chronic disorders and clinical care for children who need more care than the nurses can provide. There are also physicians, physician assistants, nurses, a dietitian and a health educator available at the clinics to provide care to the children and to support the school nurses.

“Our goal is to help these children be well and stay well,” said Christopher Dawes, CEO at Packard Children’s. “By improving access to primary care and prevention, we’re taking steps to help kids stay in school and lessen the chance they’ll need our services in the future. School nurses in the San Jose Unified School District are on the front line of this care, and we’re proud to support them.”

This project is designed as a demonstration project to test the efficacy of expanding school nursing and formally linking nurses to a school health clinic as a model for school districts struggling with increasing numbers of children needing primary care access and management of chronic conditions. It is being evaluated by Eunice Rodriguez, DrPH, clinical associate professor, Department of Pediatrics and Center for Education in Family and Community Medicine, SUSOM.

Packard Children’s provides funding, human resources and technical assistance for a broad constellation of programs that benefit children in Santa Clara and San Mateo counties. In fiscal year 2007 alone, Packard Children’s provided programs and services valued at nearly $2.7 million. By creating a framework of health care beyond our Palo Alto setting, we decrease the number of patients requiring inpatient care for disorders that can be kept under control outside the hospital or prevented altogether. This increases bed availability for patients who need it most and helps fulfill Packard Children’s mission of serving our communities and improving the health of children and expectant mothers.
LINKS Enhancements

Phase 2 of CTP has been active for more than two months, with inpatient care provider order entry (CPOE) and electronic clinical documentation established in most inpatient and peri-operative areas. Thank you for your hard work in making this rollout successful. Some of the new features and solutions rolled out since go-live include:

- Patient lists enhancements (clipboards modified to show only rad and lab results, increased the number of patient lists you can have active from 9 to 25)
- Signout (rounds) report improvements (performance improved, medication accuracy fixed, truncating brief ID fixed)
- Progress note enhancements (one- and two-page notes renamed acute care and critical care to better reflect their uses; seven-day trend for weights added)
- Rounds tab enhancements (O2 flow rates on vital sign section, I/O summary showing “6a to 6a” and “since 6a”)
- Care Summary tab now shows a calendar of significant clinical events (including all unit-to-unit transfers, intubations/extubations, central line placement/removal and procedures/deliveries)

LINKS enhancements in development include obstetric-specific progress notes (ante-partum and postpartum), NICU progress note improvements, and better labeling of central lines. We are expecting to activate CPOE and electronic documentation in the PICU early this summer, followed by the CVICU.

The Clinical Informatics Department is actively supporting and improving the LINKS system. We encourage you to send any suggestions . . .

LINKS Training

The LINKS training has been modified and made available entirely online for physicians. If you have not yet completed LINKS training, please go to http://learnlinks.lpch.org and take the modules for providers. After completing the Web-based training (WBT), you will be directed to take assessment in HealthStream at http://healthstream.com/hlc/stanford. Please read the instructions on the Web page to log in with your Physician ID/Dictation number. Then complete the LINKS assessments (multiple-choice test) that have been assigned to you. This is an important step to certify that you have taken the training and demonstrated competency with new functionalities.

Getting Access to LINKS

Getting access to LINKS is easy for credentialed medical staff. Please call the LPCH Helpdesk at (650) 498-7500 and select the option for physician assistance. Let the agent know that you are on the Packard Children’s Medical Staff and give them your Physician ID/Dictation number. You should request both the LINKS access (Cerner/PowerChart Applications) and Remote Access logins at the same time. No access forms are necessary for the medical staff.

Medication Renewals in LINKS

One major outstanding issue is medication renewals. It is critical to understand that medications will not automatically discontinue unless the ordering physician enters a duration or stop date. Medications without a specified duration need to be renewed (14 days for all meds except narcotics) but will not discontinue unless the MD enters a stop date. We are working hard on a solution to clarify which meds are due to complete (due to an MD-ordered stop date or duration of therapy), but in the meantime please carefully review your patients’ MAR and medication orders every day just as you would normally.

For more information, please contact Jin Hahn, MD, at jhahn@lpch.org or Chris Longhurst at clonghurst@lpch.org.
This regular column will provide highlights of current legislation on the state and federal level that impacts Lucile Packard Children’s Hospital and the physicians who are affiliated with the hospital. If there is specific legislation you are interested in having followed, please contact Sherri Sager, chief government relations officer, at ssager@lpch.org.

**STATE ISSUES**

The State Assembly passed the compromised Healthcare Reform package drafted by the governor with input from Speaker Núñez. On January 28, the State Senate Health Committee voted to oppose the Health Care Reform legislation. This vote by the Senate Health Committee effectively ends efforts for comprehensive health care reform. The governor has vowed to continue fighting to “fix the broken health care system” of California.

The California Children’s Hospital Association (CCHA) is circulating petitions to gather signatures to qualify a Children’s Hospital Bond Initiative 2008 for the November 2008 ballot. The bond initiative builds on the successful Proposition 61, which was passed by voters in November 2004. That bond initiative provided $750 million for capital improvements for children’s hospitals. The current initiative would provide $980 million for capital improvements for children’s hospitals. If the bond is passed by voters in November, Lucile Packard Children’s Hospital will be eligible for up to $98 million for capital improvements.

In 2007, the governor vetoed State Bill 137, which would have increased the income limits for families to qualify for the California Children’s Services (CCS) program. Early indications are that the Specialty Care Coalition plans will be reintroduced in 2008.

**FEDERAL ISSUES**

In December, the president finally signed the annual Labor/Health and Human Services appropriations bill. Included in the legislation was $301.6 million for the Children’s Hospital Graduate Medical Education (CHGME) program. This is a slight increase over last year’s appropriation and the first increase in four years. Packard Children’s received $6.8 million this year from the program.

The second issue is the reauthorization of the State Children’s Health Insurance Program (SCHIP). On its third try, Congress sent to the president a reauthorization of the program until March 2009 with enough funding to keep the program at current levels. The president signed this extension and vowed to not allow the program to expand beyond its original parameters. More to come on this, most likely after the presidential election.


When an intravenous line is required, it’s natural to think reflexively of a short peripheral IV. But the best line type and placement for your patient may be something longer term, more complex, or difficult to place. The Vascular Access program at Lucile Packard Children’s Hospital is an essential resource to help you provide the highest standard of care to your patients. VA nurses are available to evaluate the patient, advise the provider and/or place the line that best suits your patient’s overall condition.

The vascular access nurses are expert at placing peripherally inserted central catheters (PICCs), midlines, and peripheral IVs, as well as with assessing and addressing a broad range of vascular access issues, such as managing catheter occlusions and breakage and replacing non-functioning lines. They also determine the level and type of pain management and sedation that will be necessary during line placement.

Current evidence unequivocally supports the fact that the earlier a vascular access need is identified and appropriate device placed, the better the patient’s outcomes are—i.e., improved patient satisfaction, shorter hospitalizations, decrease in painful and stressful events in the hospital from repeated venipunctures, and decrease in IV therapy complications that result when inappropriate devices for the purpose and duration of treatment are selected.

Most of the patients served by the Vascular Access program fit into certain disease categories, especially related to infections, malignancies, and organ dysfunction, most commonly cystic fibrosis, leukemia, osteomyelitis, short-bowel syndrome, perforated appendicitis, and heart, liver, or renal failure. These patients often require infusions that, when given through small peripheral vessels, can cause tissue damage. For this reason, longer catheters are placed with their tips located in much larger veins where hemodilution minimizes the potential for cellular or tissue damage.

PICCs are recommended for intermediate-term IV access needs which means anticipated IV therapy of five or more days. If patients have conditions that require frequent venipuncture for blood sampling or IV restarts because they are receiving infusions that are caustic or have extreme pH and osmolality, even for a shorter term, a PICC may be indicated.

The vascular access team’s experience at Lucile Packard has been that early referrals from bedside nurses, physicians, and allied health providers are key to achieving its goal of placing the appropriate access type for the prescribed use for the appropriate duration of IV therapy.

The VA office hours are Monday through Friday, 8 am to 7 pm, and expanded operating hours are being considered. For consultations, please page extension 47422 (4PICC), place a request for vascular access through LINKS, or fax a referral form to (650) 723-7364. For questions, please contact vascular access PNP Medie Jesena at mjesena@lpch.org.
Jonathan Berek, MD, professor and chair of the Department of Obstetrics and Gynecology, has been elected president of the International Gynecological Cancer Society for three years, 2008–10. The society is the world’s largest group dedicated to research and treatment of gynecological malignancies. Berek was also elected to the Commission on Cancer of the American College of Surgeons for a three-year term.

Hugh O’Brodovich, MD, has recently been appointed professor and chair of the Department of Pediatrics. O’Brodovich was the former chair of pediatrics at the University of Toronto and pediatrician-in-chief at Toronto’s Hospital for Sick Children. His lab research focuses on the relationship between ion transport in lung epithelium and pulmonary edema and respiratory distress syndrome in newborns.

Mary Jacobson, MD, clinical assistant professor of obstetrics and gynecology, has been selected by the Association of Professors of Gynecology and Obstetrics as one of 20 scholars to participate in the APGO/Solvay Pharmaceuticals Educational Scholars Development Program. The rigorous 15-month program covers curriculum and instruction; measurement and evaluation; research statistics, and leadership and management. Jacobson will take part in the program designed to help obstetricians and gynecologists become educational leaders in the field of women’s health.
According to the American Academy of Otology/Head and Neck Surgery, ear, nose and throat disorders are the primary reason children and adolescents visit a physician. Otolaryngologists and general practitioners who treat pediatric patients require comprehensive, up-to-date information on the special issues involved in the evaluation and treatment of ear, nose and throat disorders in children.

At the conclusion of this activity, participants should be able to do the following:

- Discuss current trends in the evaluation and management of obstructive sleep apnea in children
- Identify therapeutic options for common ENT infections
- Describe treatment strategies for various airway disorders and neck masses, including laryngeal and congenital tracheal stenosis, laryngeal cysts and clefts, airway hemangiomas, thyroglossal duct cysts and brachial cleft cysts

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