MEET THE *Team*

We understand that no surgery is simple. That is why patients need surgeons who are pediatric-trained and experienced in treating a wide range of conditions. Our team of pediatric general surgeons includes:

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SURGERY Update

A newsletter from Children's Physician Group—Pediatric Surgery

Surgery Update is a newsletter from Children's Physician Group—Pediatric Surgery intended to keep you informed regarding the latest in pediatric general surgery.

In this issue

Call **404-785-6895** (Scottish Rite) or **404-785-8787** (Egleston) to make a referral or to discuss potential surgical treatments for your patients.

Visit **choa.org/CPGsurgery** for more information.

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SPRING 2016

In this issue

Children's Healthcare of Atlanta
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Advancement through innovation

By Paul M. Parker, M.D.

The modern era of pediatric surgery began around the 1940s. At that time, innovation and development was directed primarily toward the goal of being able to do procedures on neonates and young children. I began my fellowship about 30 years ago, and since that time, I have seen that goal shift toward improving approaches with technological and equipment advances, often leading to less invasiveness. As we became less invasive surgically, another era was ushered in—this one seeking alternative approaches that were not only less invasive, but also, in many cases, actually nonsurgical. What a thing for surgeons to accept!

Canadian pediatric surgeons in the early 1980s began championing the now well-known and accepted technique of enema reduction for intussusception, and nonoperative management of solid organ injuries began. This not only dramatically changed children's healthcare for the better, it also allowed for a whole new way of thinking for surgeons.

Now, instead of enduring multiple trips to the operating room, fragile neonates remain in the neonatal ICU for patent ductus arteriosus (PDA) ligations, emergent laparotomies and intestinal diversion, extracorporeal mechanical oxygenation (ECMO), and sometimes congenital diaphragmatic hernia repair. This leads to reduction in transport problems, such as heat loss or loss of access devices, and also improves communication and continuity of care finer points. We've come a long way since my fellowship when the only procedure done in the NICU was a central line placement.

In the adult surgical world, minimally invasive surgery has a specific fellowship training track. With the advent of smaller and finer equipment, many congenital anomalies are now routinely repaired with thoracoscopic or laparoscopic techniques in the pediatric world as well. Esophageal atresia with or without tracheoesophageal fistula, congenital diaphragmatic hernia, duodenal atresia, Hirschsprung's and imperforate anus pull-through procedures (often without colostomies), and many others are repaired with tiny 3-millimeter incisions. To some degree, these techniques are better cosmetically, which may have been the primary interest driving the development of minimally invasive surgery; but to a larger degree, they reduce other morbidities—like intestinal adhesions, potential scoliosis later in life from rib-spreading thoracotomies, and, of course, pain. Surprisingly, we have found that the benefits are not only for the patients. In many cases, minimally invasive techniques actually improve the surgeon's visualization (for example, anti-reflux surgery and recto-urethral fistula closure with imperforate anus).

The thoracoscopic treatment of congenital lung lesions (CPAM, or congenital pulmonary airway malformations and sequestration) has advanced to the point where it is essentially routine. However, now we are beginning to question not only when but whether all actually need to be removed. Long-term dogma dictated removal of all of these lesions as young neonates to avoid potential infection, perforation, bleeding or degradation to malignancy. Although the prevailing current opinion is that most still need to be removed, we know that it is safe to delay removal until after the neonatal period.

With the advent of new studies indicating potential adverse neurological development effects of anesthesia on the very young child, we now delay almost all nonemergent procedures until after 6 months of age. Elective procedures, like removal of congenital remnants in the neck, for example, should be delayed. However, we still are not sure hernia repair should be delayed that long.

These are just a few of the many examples of improvement in care brought on by our ability to begin to question long-held concepts. Now that we have accepted this way of questioning surgical dogma, we can think creatively about solutions in surgery. However, we must also question whether the newer ideas are actually better, and not just accept them because they are less invasive, less expensive, newer or easier on the surface.

This is where the burgeoning field of outcomes analysis will help move from an era of "gut feeling" to one of actual long-term data comparing results.

Our faculty is dedicated to surgical quality and outcomes research. Drs. Kurt Heiss, Amina Bhatia, Mehul Raval and Matthew Santore are devoting much of their time and efforts to make Children's a national leader in outcomes research for pediatric surgery and pediatric trauma care.

It took a big shift in the way we think to bring about these improvements. Surgeons were finally open to not only less-invasive care, but also noninvasive care, and were still able to maintain that they were real surgeons at the end of the day. But none of us can be successful without other specialties just as dedicated to pushing limits of time-honored dogma. The concomitant improvements in pediatrics, intensive care, neonatology, anesthesia and industry have allowed us the opportunity to explore innovative options for children's healthcare, and we look forward to further advances in the next 50 years.

Pelvic and Anorectal Care Program now offering Bowel Management Program

The Pelvic and Anorectal Care Program at Children's provides medical care for children with surgical diseases resulting in constipation, diarrhea, soiling, and/or pain. Diagnoses include anorectal malformations (ARM) such as imperforate anus and cloaca; Hirschsprung's disease (HD); pelvic and spinal tumors; tethered cord; neurogenic bowel and bladder; spina bifida (SB); refractory constipation/idiopathic constipation that has not been successfully treated by gastroenterology; and fecal incontinence due to neurological involvement. Though some of these children's anomalies can be "fixed" anatomically with surgery, all of these children face a lifelong problem of incontinence. The Pelvic and Anorectal Care Program provides ongoing care to these children with daily therapies that keep them clean and continent for both urine and stool on a daily basis.

Approximately 3,000 children will be born each year with an ARM, HD or SB. These kids now have a place in Georgia where they can receive comprehensive surgical and medical care for all colorectal, genitourinary and motility issues. Our clinic is staffed weekly by John Bleacher, M.D., Megan Durham, M.D., Kurt Heiss, M.D., and George Raschbaum, M.D. (general surgery); Edwin Smith, M.D. (urology); Jose Garza, M.D. (GI); and Kathleen Hoff, P.A.-C.

Not only do we offer traditional weekly clinics, but we also have begun a specialty care program throughout the year called Bowel Management Booty Camp. Booty Camp is a seven-day outpatient program for children dealing with fecal incontinence, along with their parents or caregivers. Each day the child and family is seen by the team and their bowel regimen is modified based on their clinical and diagnostic presentation for the previous 24 hours. The goal of this intensive program is to identify the correct bowel management regimen for the child to be clean every 24 hours during that one-week period. Not only do our patients receive medical care, but they also feel the camaraderie that comes with being at camp and realize they are not alone.

We have recently expanded national relationships as a founding member of the Pediatric Colorectal and Pelvic Learning Consortium (PCPLC) spearheaded by Nationwide Children's Hospital and Utah Children's Hospital. We have also been awarded a Quick Wins grant in collaboration with Georgia Tech and Emory University to create an app to assist with medical therapy education and compliance with prescribed protocols (reminders of important treatment times, medications and therapies), as well as assisting with a stool/urine diary and appointment reminders.

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Dr. Clifton

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Drs. Heiss and Wulkan

Surgical locations

We perform surgeries at Egleston hospital, Scottish Rite hospital, Children's at Meridian Mark Outpatient Surgery Center and Children's at Satellite Boulevard Outpatient Surgery Center.