

# Pediatrics Section Newsletter

Fall 2015

## Letter from the Pediatric Section Chair



Greetings and Happy Fall!

With the cooler weather comes an increased pace of life. There are holidays to celebrate and the New Year just around the corner. Recently, I along with Kelly Green-Corkins MS, RD, LDN, CNSC, chair elect of the Section, had the privilege of attending the A.S.P.E.N. Leadership Retreat. It was an informative meeting where Kelly and I were able to learn more about the future direction of the organization and new endeavors. Described below are some upcoming opportunities that you may want to take advantage of.

First, do not forget that nominations for the Pediatric New Practitioner award are due November 30<sup>th</sup>. This award is a wonderful way to recognize a professional new to the area of pediatric nutrition support and to foster his/her career development. The award recipient does not have to be new to the field of nutrition support, but must have just started practicing in pediatrics within the last two years. Within this newsletter you will find more detailed information

about the application process and a letter from last year's award winner, Lingxia Sun MS, RD, about how this award has benefited her practice.

A.S.P.E.N. has recently made webinars available to Sections as a way to share information about the latest research in the field of nutrition support. We are very excited to participate in this new opportunity and have registered to host a webinar in February. Currently, we are accepting ideas of topics and speakers. If you have a topic that you think would be pertinent to the group or if you would like to speak please email me directly at [ebobo@nemours.org](mailto:ebobo@nemours.org).

In October, A.S.P.E.N. hosted Malnutrition Week. I hope many of you were able to participate in the events. If not, I encourage you log on to the website at [www.nutritioncare.org](http://www.nutritioncare.org) and look at the available information located in the "Malnutrition Toolkit". In particular, I would like to draw your attention to the pediatric malnutrition screening algorithm. We all are aware that malnutrition is more prevalent than it is reported. I challenge you to start reporting malnutrition in your practice so that it can receive the awareness it deserves.

Sincerely,  
Elizabeth Bobo, MS, RD, LD/N, CNSC

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## Clinical Nutrition Week January 16-19, 2016: Austin Texas!

Clinical Nutrition Week is coming up, don't miss out on a wonderful opportunity for education, networking, and career advancement. There is still time to register! The preliminary program is also available on the A.S.P.E.N. website so you can check out the available sessions. Many pediatric focused sessions are available and as always the Pediatric Section will be hosting a meeting and program that you won't want to miss. Keep an eye out for more information about Clinical Nutrition Week as the conference nears.

[A.S.P.E.N. Clinical Nutrition Week 2016](#)

## Pediatric Section Microsite

Visit the Pediatric Section microsite to access past versions of the newsletter, the Hot Topic of the Quarter survey, current research updates, and much more!

[Pediatric Section Microsite](#)

## Member Spotlight: Jane Balint, MD

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### **What is your current job title and work location?**

I am the Co-director of the Intestinal Support Service (our inpatient and outpatient intestinal rehabilitation team) and an attending physician in Pediatric Gastroenterology, Hepatology and Nutrition at Nationwide Children's Hospital and The Ohio State University in Columbus, Ohio.

### **What is your educational background?**

I have a bachelor's degree in nursing from the State University of New York at Albany and a master's degree in nursing with a pediatric nurse practitioner certificate from the University of Virginia. After working as a nurse and nurse practitioner for 10 years, I went back to medical school at Albany Medical College in upstate New York. From there I went to the Children's Hospital of Philadelphia for my pediatric residency and on to Cincinnati

Children's Hospital Medical Center for a fellowship in pediatric gastroenterology, hepatology, and nutrition.

### **How did you get involved in the field of clinical nutrition?**

It started in the late 1970s when, as a nurse I was fortunate enough to have the opportunity to care for children on parenteral nutrition, two of whom in particular stimulated my passion for this area and stole my heart. Dr Lyn Howard who was their physician was an inspiration. My involvement in this area was further solidified along the somewhat winding path of my career. As a nurse practitioner, I worked with Brad Rodgers a pediatric surgeon at the University of Virginia; the children who needed the most time and attention were those with what is now called intestinal failure. As a pediatric resident, my first rotation was on the GI service, again taking care of children with intestinal failure, learning all of the things that could go quickly wrong if we were not paying very close attention (I got to know the ICU attendings very well that month) but also recognizing and appreciating what nutrition support could do. The final step was during my fellowship. One of our clinic rotations was the Comprehensive Nutrition Clinic. My co-fellow and I were given the opportunity to follow a cohort of our own patients throughout our fellowship. This was an incredible learning opportunity and I was

completely hooked. Jackie Wessel, Gerry Hennies, and Kim Klotz (the dietitian and nurses on the team) were incredibly generous with their time and, as I have said very often, taught me everything I know about nutrition support including the importance of the team. This is not to diminish what I learned from my attendings, Mike Farrell and Jim Heubi and the two surgeons, Drs Mory Ziegler and Brad Warner who patiently helped me understand critical medical and surgical aspects of care. The children and their parents were also amazing teachers. Who would not want to care for these children with the opportunities and rewards that come with it?

**What specifically do you do in your current position?**

We have a dedicated inpatient service for patients with intestinal failure that one of my partners and I are responsible for along with two nurse practitioners, so half of the year I am the inpatient attending for that service. We have several planned clinics each week for our short bowel/intestinal failure patients. In addition, because of the nature of their problems, we also have a fair number of unplanned visits. Our goal is to try to avoid the need for children to go to the Emergency Department. This can make for an unpredictable and sometimes chaotic day but we believe that this provides the best and most efficient care for those with complicated medical problems as we already know them well. We have fellows in our program, so an important aspect of my position is teaching the next generation of pediatric gastroenterologists about the care of those needing nutrition support and other aspects of nutrition care. An important part of what I do is collaborating with other members of both our core team (dietitian, motility physician, nurses, nurse practitioners, pharmacist, radiologist, surgeon) and others who are involved in the care of our patients both at our center and at other centers. I have an open door and try to help when anyone has a question about a patient or a problem or wants to just discuss an idea. Other aspects of my position include being a member of the Nutrition Support Team, serving as medical director of Clinical Nutrition, participating on several hospital committees, speaking, writing, and acting in a support role with several clinical research projects.

**Why did you become involved in A.S.P.E.N. and what are the benefits of being involved?**

ASPEN is the organization that has a focus on nutrition support so is a great fit for me professionally. Working in a field where there is often not as much evidence as we would like on which to base practice, ASPEN provides the opportunity to meet and talk with others and learn from them both in person at meetings and electronically through forums. Where there is evidence, ASPEN has an impressive array of resources that can easily be accessed. It provides an array of opportunities for continuing education. ASPEN is also an organization that is very open and so provides opportunities to be active even as a newcomer.

**What recommendations would you give to someone just starting out in your field?**

Be open to opportunities, when a door opens walk through it - on the surface, something may not be what you think you are interested in or want to do (or feel competent to do) but may introduce you to people who will help you in your career or to something that captures your passion. In a similar vein, volunteer for committees or projects; this is a great way to learn and to meet people and is always appreciated. Never be afraid to ask a question, no question is ever "dumb". I have found that those who are leaders in the field are not unapproachable but rather are almost always incredibly gracious people who are more than willing to share what they know and help if they can.

## Results from the Indirect Calorimetry and Predictive Equations Topic of the Quarter Survey

Note: Not all response percentages add up to 100% as not all questions were answered by all respondents

1. Does your institution use indirect calorimetry in pediatric patients?
  - a. Yes 54.35%

- b. No 45.65%
2. What population is indirect calorimetry used in?
    - a. PICU 65.38%
    - b. NICU 3.85%
    - c. Surgical patients 0%
    - d. General pediatrics 11.54%
    - e. Unsure 0%
    - f. Other 19.23%

Other responses: Mostly in the research setting, pediatric cardiac ICU and cardiac step down, Neuro ICU, burn unit, chronic kidney disease patients, bone marrow transplant patients, and obesity.

3. What are the criteria that qualify a patient for indirect calorimetry?
 

Multiple respondents were unsure of criteria or stated that none existed at their institution. Other responses were for the following populations: ICU patients, burn patients, any patient on which indirect calorimetry is feasible, intubated patients, underweight or overweight patients, and those with significant weight loss.

4. Who completes indirect calorimetry in your institution?

- a. Dietitian 36.0%
- b. Physician 8.0%
- c. Nurse 4.0%
- d. Nurse Practitioner 0%
- e. Other 72.0%

Other responses: Respiratory therapist or trained technician

5. If completed, how often is indirect calorimetry repeated during the hospital stay?

- a. Weekly 20.0%
- b. Monthly 4.0%
- c. Not repeated 12.0%
- d. Based on significant clinical changes 60.0%
- e. Other 24.0%

Other responses: Variable or whenever possible

6. If you do not use indirect calorimetry what are the barriers to doing so?

- a. Cost of the equipment 61.54%
- b. Lack of appropriate training 42.31%
- c. Do not feel it is useful or necessary 15.38%
- d. Other (please add a comment box) 38.46%

Other responses: Time consuming, lack of validated equipment for pediatric patients, lack of equipment able to measure NICU infants

7. Does your institution use predictive equations to estimate energy needs?

- a. Yes 92.68%
- b. No 7.32%

8. If No, what method is used to estimate energy needs?

Responses: RDA, DRI, and charts from Ekhard Ziegler

9. What predictive equation do you use most often?

- a. Harris-Benedict 12.50%
- b. Caldwell-Kennedy 2.50%
- c. Schofield 57.50%
- d. FAO/WHO/UNU 70.0%

- e. White 2.50%
- f. Maffeis 0.0%
- g. Fleisch 0.0%
- h. Kleiber 2.50%
- i. Dreyer 2.50%
- j. Hunter 2.50%
- k. Other 25.0%

Other responses: kcal/kg recommendations, Seashore, catch up growth based on growth charts, EER, and Penn State for older teens

**10. What predictive equation do you use for overweight/obese patients?**

- a. Harris-Benedict 13.16%
- b. Caldwell-Kennedy 2.63%
- c. Schofield 39.47%
- d. FAO/WHO/UNU 50.0%
- e. White 2.63%
- f. Maffeis 2.63%
- g. Fleisch 0.0%
- h. Kleiber 2.63%
- i. Dreyer 0.0%
- j. Hunter 2.63%
- k. Other 39.47%

Other responses: Molnar, Lazzer, kcal/kg based on ideal body weight, RDA using adjusted body weight, kcal/kg using permissive underfeeding except for in the burn population, Ireton-Jones, Penn State, and TEE.

**11. If you use certain predictive equations for specific patient populations please specify.**

Responses:

Burn patients- Schofield, Mayes

NICU patients- WHO, kcal/kg

PICU patients over 10 years of age- Mifflin- St. Jeor

The section would like to extend a huge thank you to all of our members who provided your valuable feedback in the survey. Suggestions for future surveys can be filled out at the end of the new Hot Topic of the Quarter Survey or sent to Celina Scala at [Celina\\_M\\_Scala@rush.edu](mailto:Celina_M_Scala@rush.edu).

**[New Hot Topic of the Quarter Survey: Enteral Feeding Concentrations and Modular Products](#)**

Please complete this survey before it closes on December 31<sup>st</sup>, 2015.

[Hot Topic of the Quarter: Enteral Feeding Concentrations and Modular Products](#)

**[Nominations for the A.S.P.E.N. Pediatric New Practitioner Award](#)**

Nominations are due to November 30<sup>th</sup>. Nominees can be either new practitioners or those new to pediatrics within the past 2 years. Nominations can be submitted using the attached form and more information can be found at the link below.

[http://www.nutritioncare.org/About\\_ASPEN/Professional\\_Awards/A\\_S\\_P\\_E\\_N\\_Awards/](http://www.nutritioncare.org/About_ASPEN/Professional_Awards/A_S_P_E_N_Awards/)

**[A note from the winner of the 2015 A.S.P.E.N. Pediatric New Practitioner Award: Lingxia Sun, MS, RD](#)**

The Pediatric Section would like to congratulate Lingxia Sun on her exemplary work and on receiving this award.

In Lingxia's own words:

"My first medical nutrition therapy class introduced me to A.S.P.E.N. After becoming a recipient of the A.S.P.E.N. Student Sponsorship Award, I joined A.S.P.E.N. as a student member in 2013. A.S.P.E.N. journal articles and nutrition support resources have been great references for my job as a pediatric nutrition support clinician.

It has been a great honor to receive the 2015 A.S.P.E.N. Pediatric New Practitioner Award. The award is recognized by my employers, as well as my alma mater, Tufts University. The news of me receiving this award is to be posted on the Tufts Nutrition Magazine in the Alumni news.

In the past year, I have been seeking more research opportunities to promote pediatric nutrition support research and practices. A couple weeks ago, I was selected as a future leader to attend the 2015 A.S.P.E.N. Leadership Retreat. I feel privileged to have the opportunity to network with leaders in the field of nutrition support and pursue my professional development.

I strongly encourage new practitioners involved in pediatric clinical nutrition support to apply for this award to further enrich their professional development. "

### Research Updates-Call for Volunteers!

If you are interested in providing research updates for any pediatric specialty area, such as oncology, neurology, nephrology, etc., to be included in the quarterly newsletters please contact Celina Scala at [Celina\\_M\\_Scala@rush.edu](mailto:Celina_M_Scala@rush.edu).

### NEW! Recent Pediatric Enteral Feeding and Central Line Studies

Beth Lyman, of the NOVEL Project, has compiled a list of recent pediatric enteral feeding and central line studies from PubMed. This is another great resource for keeping up to date on the latest nutrition research. For the full list of articles please visit the Pediatric Section Microsite using the link below. [Pediatric Section Microsite](#)

### Pediatric GI Research Updates

Provided by Marisa Dzarnoski Riley, RD, CNSC

**Pediatric intestinal failure: Predictors of metabolic bone disease**  
Study design: Retrospective

This study was a single-center retrospective study of a cohort of intestinal failure (IF) patients seen between January 1988 and November 2009, looking to identify risk factors for the development of metabolic bone disease in pediatric intestinal failure patients. The study found significant correlation with duration of PN-dependence. Vitamin D deficiency and hyperparathyroidism were common in this population, but neither marker was predictive of decreased bone mineral density. Of those patients who had a repeat DXA, there was poor improvement to bone mineral density despite interventions. *Demehri FR, Simha S, Stephens L, Harris MB. Pediatric intestinal failure: Predictors of metabolic bone disease. J Ped Surg. 2015; 50: 958-962.*

### Neonatal Research Updates

Provided by Jackie Wessel, Med, RDN, CNSC, CSP, CLE

## **Shielding Parenteral Nutrition from Light Improves Survival Rate in Premature Infants: a Meta-Analysis**

Study design: Meta -Analysis

This article reviews 4 trials, 800 newborns total in regards to shielding parenteral nutrition completely, from manufacture to delivery from light; shielding not only the bag but also the tubing. In this review the mortality rate before 36 weeks was half that in the protected group versus the infants with un-protected parenteral nutrition. Light exposure increases the oxidant exposure to premature infants. In animal studies the peroxidases generated by TPN are associated with lung remodeling and hepatic steatosis. The peroxide load is reduced when TPN is shielded from light. Interestingly, cells from male infants are less resistant to peroxides than cells from female infants. In animals metabolic complications ensue after only 4 days of light exposed parenteral nutrition at birth. The 4 studies were not blinded as it would not be possible. The conclusion was that there should be photo-protected systems for TPN and lipids in the infusion sets for premature infants and that further research should be done especially in the long term TPN populations of infants, children, and adults.

*Chessex P, Laborie S, Nasef N, et al. Shielding Parenteral Nutrition from Light Improves Survival Rate in Premature Infants: a Meta-Analysis. J Parenter Enteral Nutr. 2015; 20:1-6.*

[Shielding Parenteral Nutrition From Light Improves Survival Rate in Premature Infants: A Meta-Analysis](#)

## **Impact of surgery for Neonatal Gastrointestinal Disease on Weight and Fat Mass**

Study design: Case Controlled Observational Study

This study looked at growth of surgical infants in one unit from 2012 to 2014. There was a gestational age matched control group. The surgical neonates were shorter, had lower weight and lower fat mass than their peers despite receiving more parenteral nutrition. Different theories as to why this may occur are presented. This is a good article for those that deal with the surgical neonate to read. Some limitations are that the study was not bigger and that they did not include long term follow-up with neurodevelopmental testing

*De Cunto A, Paviotti G, Travan L, et al. Impact of surgery for Neonatal Gastrointestinal Disease on Weight and Fat Mass. J Pediatr. 2015; 167:568-571.*

## **Early Enhanced Parenteral Nutrition, Hyperglycemia, and Death Among Extremely Low Birth Weight Infants**

Study design: Observational Study

This study looked at the prevalence of hyperglycemia before and after an early enhanced parenteral nutrition protocol was put into place. The years studied were 2002-2005 and 2006-2011, all in one center in Norway, 343 ELBW infants. With the start of the new protocol infants were getting more nutrition including a higher glucose infusion rate and higher protein. I would say that this new protocol is still not as aggressive as a standard protocol in the US. The older protocol was really older in comparison to US standards, D 10 for several days and then amino acids added and lipids.

In their study babies were divided into early, moderate, and severe hyperglycemia. Babies with severe hyperglycemia had a higher risk of dying whether early or late. There was no difference in mortality using the new protocol in the multivariable model when severe hyperglycemia, gestational age, and CRIB scores were taken out. This paper discusses the many reasons for hyperglycemia and discusses the observation by Mahaveer et al and Burattini et al that early higher protein may stimulate endogenous insulin production. Interestingly this paper states that the use of insulin in these patients remains controversial, and that it should only be used for cases of refractory hyperglycemia.

*Stensvold hj, Strommen K, Lang AM, et al. Early Enhanced parenteral Nutrition, Hyperglycemia, and Death Among Extremely Low Birth Weight Infants. JAMA Pediatr 2015; doi:10.1001/jamapediatrics.2015.1667.*

## **Nutrition practice, compliance to guidelines and postnatal growth in moderately premature babies: the NUTRIQUAL French study**

Study design: Survey

This was a study that looked at the results of a questionnaire sent to each NICU unit in France and affiliated territories. The moderately preterm infant (30 to 33 weeks) has not been studied extensively even though they account for 15% of preterm live births and 30% of NICU admissions. ESPGHAN has published guidelines as described in the Koletzko et al paper from JPGN 2005 41 suppl 21-87. It was found that nutrition was not in compliance with recommendations and extra-uterine growth restriction was common in this cohort of patients. I thought that since many of us are searching for guidance in this population, this is an interesting and informative paper.

*Iacobelli S, Viaud M, Lapillone A, et al. Nutrition practice, compliance to guidelines and postnatal growth in moderately premature babies: the NUTRIQUAL French study. BMC Pediatrics . 2015; 15:110-116.*

### **Association between Transient Newborn Hypoglycemia and Fourth Grade Achievement Test Proficiency A Population Based Study**

Study design: Population Cohort Study

This was a study of all patients in 1 year at 1 center that had at least 1 recorded glucose level <35, <40, and <45; which occurred in 6.4%, 10.3%, and 19.3% of newborns. They matched 72% of the newborns with their achievement test scores at age 10. In general, hypoglycemic infants were smaller, less mature, and more commonly from multifetal gestations. This study is very concerning for practitioners; we wait for some to validate these results. If they are validated it will change universal newborn glucose screening.

*Kaiser JR, Bai S, Gibson N, et al. Association between Transient Newborn Hypoglycemia and Fourth Grade Achievement Test Proficiency A Population Based Study. JAMA Pediatric . 2015; 169:913-921.*

### **Biological Impact of Recent Guidelines on Parenteral Nutrition in Preterm Infants: A Systematic Review**

Study design: Systematic Review

This is an interesting review of the newer parenteral guidelines for premature infants which have experienced difficulties with homeostasis as a result of the earlier amino acids without other supportive nutrients. Problems include hypophosphatemia and hypercalcemia, both of which could be prevented by the early intake of phosphorus. Attempting to induce anabolism is a problem if the other nutrients are not added. This is an interesting article that reviews issues with our current parenteral therapy.

*Guellec I, Gascoïn G, Beuchee A, et al. Biological Impact of Recent Guidelines on Parenteral Nutrition in Preterm Infants: A Systematic Review. J Pediatr Gastroenterol Nutr 2015, Jul 2 e pub.*

### **One Extra Gram of Protein to Preterm Infants from Birth to 1800 g: a single blinded randomized clinical trial**

Study design: Randomized Partially Blinded Clinical Trial

This study used additional protein in both parenteral and enteral nutrition. The infants were ELBW 500 to 1249 grams, 160 infants in total. Both groups started protein at 1.5 gm/kg/day and increased by 0.5gm/kg to a maximum of 2.5 gm/kg in the standard group at DOL 3 and 3.5 gm/kg at DOL 5 in the high protein group. The non-protein energy, mineral, and trace elements were similar. Minimal enteral feedings were started on the first day of life at 8 ml/kg/day and was constant for 3 days, then increased by 16 ml/kg from day 4 to 7. After day 7 according to the birth weight they were advanced at 8, 12, or 16 ml/kg/day. Maternal human milk was encouraged. Banked human milk or preterm formula was also used. The protein calculations used for calculations of preterm (1.9 gm/100 ml) and banked milk (1.3 gm/100 ml) were higher than typically seen, especially in our experience in Cincinnati for donor milk. They used 1.3 g protein per 100 ml. The reference used for the donor milk was the Anderson et al article from AJCN from 1983. I would have thought that information article by Arslanoglu S, Moro GE, Ziegler EE. Preterm infants fed fortified human milk receive less protein than



they need. *J Perinatol.* 2009;29:489-92 would have been used. Fortification was done 15 days after birth. Beneprotein was used to augment protein when the PN was tapered. The intervention ended at 1800 gm.

The study did not find any advantage of the intervention group at the 2 year follow-up in either body size nor in neurodevelopment. A huge limitation is that the additional protein was less than commonly used and it occurred rather late. There is a concept from the Joseph Neu, ed. *Gastroenterology and Nutrition Questions and Controversies 2<sup>nd</sup> ed* in the series *Neonatology Questions and Controversies* Elsevier, 2012, that discusses the potential for growth that may occur very early and if that “window” is missed it may be hard to overcome later. The results from this article appear to be in contrast to other articles. These discrepancies may be related to the fact that their protein was low compared to ESPGHAN standards, and that delivery occurred later (5 days for 3.5 gm/kg protein).

*Bellagamma MP, Carmenati E, D’Ascenzo R, et al. One Extra Gram of Protein to Preterm Infants from Birth to 1800 g: a single blinded randomized clinical trial. J Pediatr Gastroenterol Nutr 2015. DOI: 10.1097/MPG.0000000000000989*

## General Pediatric Research Updates

### **Pediatric Malnutrition: Putting the New Definition and Standards Into Practice**

Study design: Review

This study aimed to review the new definition and standards of practice for pediatric malnutrition published in 2013 by Mehta et al and in 2014 by Becker et al and provide practical information for implementation. The authors identified populations in which malnutrition assessment may be challenging, such as in patients with chronic illness-related height stunting, cystic fibrosis, eating disorders, and neonates and premature infants. Described in the article is also the process used at Texas Children’s Hospital to implement the pediatric malnutrition recommendations.

[Pediatric Malnutrition: Putting the New Definition and Standards Into Practice](#)

### **Splanchnic Tissue Oxygenation for Predicting Feeding Tolerance in Preterm Infants**

Study design: Prospective

This study utilized near-infrared spectroscopy (NIRS) to measure splanchnic regional oxygenation (rS<sub>2</sub>S) and splanchnic fractional oxygen extraction ratio (FOES) to determine if they could predict feeding intolerance in preterm infants. Feeding intolerance often prolongs the amount of time that it takes preterm infants to achieve full enteral feeds. NIRS measurements were taken within 24-72 hours of life during continuous enteral feedings in infants between 25 ±0 and 31±6 weeks. A total of 28 infants were studied. The researchers found no relationship between rS<sub>2</sub>S and FOES and time needed to reach full enteral feeds.

[Splanchnic Tissue Oxygenation for Predicting Feeding Tolerance in Preterm Infants](#)

## A.S.P.E.N. Connect: Communities, Discussion Posting and Cross-Posting

As you are aware by now, A.S.P.E.N. Connect is a great tool for networking with fellow A.S.P.E.N. members and to share ideas and look for advice. A.S.P.E.N. Connect can be used to post a discussion question that other A.S.P.E.N. members can reply to. Once you are logged into A.S.P.E.N. Connect you can search under the “Communities” tab to see which communities you currently subscribe to as well as all of the communities A.S.P.E.N. offers. By subscribing to a community you will receive specific discussion posts and other information for that particular community.

If you wish to post a discussion message use the “Participate” tab to then select the “Post a Message” tab. This will open the message window where you can create your message and specify which

communities the message will be sent to. Watch the A.S.P.E.N. Connect video using the link below for more information.

[A.S.P.E.N. Connect- Communities and Cross-Posting](#)

### [A.S.P.E.N. Mentoring Program](#)

Are you interested in sharing your experience and expertise with another A.S.P.E.N. member? Would you like to learn from a fellow A.S.P.E.N. clinician? If so A.S.P.E.N.'s new mentoring program is right for you! Set up a profile as either a mentor or mentee at the link below to be paired with another A.S.P.E.N. clinician. Don't miss this great opportunity to network and grow both personally and professionally.

[A.S.P.E.N. Mentoring Program](#)

### [Member Updates and Spotlight](#)

We want to hear from you! The A.S.P.E.N. Pediatric Section group is proud of the many accomplishments of our members and we'd like to highlight what you're doing. If you have any feedback or ideas, noteworthy awards, presentations, published research, or projects that you'd like to share with our members please let us know by contacting the section group newsletter editor Celina Scala at [Celina\\_M\\_Scala@rush.edu](mailto:Celina_M_Scala@rush.edu).