



## Looking Ahead – Putting the ‘Pediatric’ in Pediatric Cardiologist

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The month of December evokes a multitude of emotions—incredulousness that the year flew by, perhaps relief that the year flew by, excitement for the holidays, a little worry about the surging viruses and what is yet to come, and gratitude for the opportunity to start doing it all again in a few weeks. It is also a time for reflection and looking ahead. Wrapping up a week of clinical service in the cardiac intensive care unit (and reading an email about MOCA Peds cycle starting next year), I realized that two of the most frequent questions asked to me by the parents this week were (1) when can my child eat? and (2) when can I hold her/him? These questions, alongside this [month’s edition of \*Pediatrics in Review\*](#), choc-a-block with bread-and-butter pediatric topics, reminded me that pediatric medicine, general and specialty, is often about getting the simple things right.

As a specialist working with children with critical heart disease, knowing general pediatrics has perhaps never been more important in my practice. Babies with prenatally diagnosed heart disease land directly from the delivery room into the cardiac intensive care unit, with cardiologists and intensivists responsible for the Barlow and Ortolani maneuver testing, as well as recognizing neonatal acne. A baby as young as 7 days old can receive a ventricular assist device, and as she grows, the questions about the spot on the back of her neck are fielded by the heart transplant physician: is it a nevus flammeus? Or is it a sign that her anticoagulation needs to be reduced? Babies with heart disease spit up—after all they are babies first—and my mind always rushes to heart failure being the cause. But what about other common things, like formula intolerance? Personally, I am embarrassingly dependent on our nutritionists and gastrointestinal specialists to help navigate the formula menu for babies, even though “feeding and growing” is easily the most important thing we monitor for and desire for our babies with the most complex heart diseases, who need to grow bigger for surgery. Plus, as the field advances to focusing beyond survival after surgery to a full quality of life after surgery, we are learning that neurodevelopmental delays and mental health problems are very common in children with congenital heart disease. We are also finding that referrals for developmental care and interventions are sadly very inconsistent. As their cardiologists, we have the ability to impact the follow-up these patients receive, by appropriate counseling of the families when we see them in cardiology clinics, astute pediatric history and examinations, and timely referrals.

And this is not limited to just the field of pediatric cardiology and critical care. As lung transplant physicians, oncologists, nephrologists, et al can attest, we all often receive questions from parents about rashes and viral infections and gastroenteritis that may have nothing to do with their child's lung transplant, bone marrow transplant, or nephrotic syndrome. But as their child's lifelong doctor for their life-changing disease, the parents are looking to the specialists for guidance (and sometimes reassurance that it is *not* the lung transplant, bone marrow transplant, or nephrotic syndrome). And they also happen to be the providers the parents often implicitly trust. With that position of great privilege comes the great responsibility of also being a good pediatrician. So this December, amidst all the sundry emotions and reflections, the motivation to fulfill the "pediatrics" aspect of my role as a "pediatric cardiac intensivist" is running high. Because the questions about timing of circumcision for our babies with hypoplastic left heart syndrome (fun fact: after their Glenn operation) or the draining eye with a compromised nasolacrimal duct are not about to stop. And the joy and satisfaction of being the pediatrician *and* the pediatric cardiac intensivist for the relieved family are pretty hard to beat.

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