

# AAP NEWS

www.aapnews.org

PUBLISHED MONTHLY  
American Academy of Pediatrics  
141 Northwest Point Blvd. • Elk Grove Village, IL 60007

AAP News, the official newsmagazine of the American Academy of Pediatrics, is dedicated to informing, educating and inspiring readers on matters related to pediatric health care.

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## SECOND OPINIONS

### Caring for children with cleft palate

As pediatric director of the Craniofacial and Cleft Center in Tampa and St. Petersburg, Fla., I am writing to clarify issues raised by Howard M. Saal, M.D., FAAP, in the article titled, "Sometimes rules must be bent for children with cleft palate" (*AAP News*, July).

Like Dr. Saal, we promote breastfeeding and encourage mothers to pump their breast milk and use one of the special bottles that do not require the baby to create negative pressure. Like Dr. Saal, when infants have Pierre Robin sequence, we often use prone (and side lying) positioning to improve airway dynamics.

However, we always obtain a sleep study to evaluate sleep disordered breathing and to assure adequate oxygenation. The sleep lab studies these children side lying, prone and supine (if tolerated). Additionally, they are evaluated during feeding and in a car seat to determine which positions and activities are safe.

We always train the parents in CPR and use apnea monitors when prone positioning is required. Because it is known that the prone position places the child at risk for sudden infant death syndrome, we feel this group of children is at heightened risk. As newborns, they often require positioning with car beds rather than car seats. Pediatric pulmonology provides follow-up and determines when another sleep study is needed.

It is important to realize that children with Pierre Robin sequence may develop increasing respiratory symptoms and increasing difficulty in feeding as they approach 2 months of age. It is important to alert parents to this pattern so that it will not be unexpected.

Management of some infants with Pierre Robin sequence has been dramatically improved with mandibular distraction to lessen the effects of micrognathia acutely. This has allowed some to avoid tracheotomy or to lessen the time that tracheotomy has been needed.

Some children require supplemental feeding techniques and high calorie formula. Therapists with spe-

cialized training in newborn feeding are extremely helpful in managing these children. Newborn hearing screening is essential. Genetic evaluation is needed due to potential genetic diagnoses, which have an increased risk of recurrence in the family.

Pediatricians should ensure that families are aware of resources available through the American Cleft Palate Craniofacial Association. It is in its 60th year and provides contact information for Cleft Palate Teams throughout the United States at (919) 933-9044. These interdisciplinary teams are experienced and will provide assistance. Pediatric pulmonology, pediatric otolaryngology, pediatric gastrointestinal and neonatology specialists also play important roles in management of these children. As the child grows, Cleft Palate Team follow-up will be ongoing for optimal dental, orthodontic, audiology, speech and plastic surgery care.

Mary H. Pavan, M.D., FAAP  
St. Petersburg, Fla.

### Downside to academic medicine

I read with interest the article in the July *AAP News* titled "The changing face of an academic career."

I am a board-certified and recertified pediatric gastroenterologist, practicing full-time pediatric gastroenterology in private practice. I chose to go into private practice and not academic medicine for two reasons. The first is that in my private practice, all my patients receive care by fully trained personnel, and I believe this provides better medical care for them than they would receive in an academic setting, where much care is provided by trainees.

The second reason is that working conditions for pediatric subspecialists, especially clinicians, in academic medicine are very poor. In most cases, clinicians in academic medicine are grossly overworked and underpaid. Furthermore, they have no opportunity for professional advancement.

Clinicians are needed in academic medicine, but they

## PORTRAIT



### Hoop dreams

Anything is possible as the new school year gets under way.