NEWS

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los angeles pediatric society

FROM THE PRESIDENT

Martha Rivera , M.D.

MAKING A DIFFERENCE



"The majority of us lead quiet, unheralded lives as we pass through this world. There will most likely be no ticker-tape parades for us, no monuments created in our honor.

But that does not lessen our possible impact, for there are scores of people waiting for someone just like us to come along; people who will appreciate our compassion, our unique talents. Someone who will live a happier life merely because we took the time to share what we had to give.

Too often we underestimate the power of a touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring, all of which have a potential to turn a life around. It's overwhelming to consider the continuous opportunities there are to make our life felt."

(Quote by Leo Buscaglia)

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As summer draws to a close, vacations end and the new school year begins; the rat race again becomes a daily way of life for many. It is a time to reflect and renew our roles as physicians and caregivers.

I have come to realize how wonderful it is to be placed in a role of physician and friend to many patients. Our care not only encompasses physical medical care, but also includes emotional support to our families. By spending time with and taking time to listen to our families, we can provide a wealth of information and empathy in many situations.

Although we do not receive formal training in grief counseling, we may be the first to be encountered when a family crisis arises. I have come to realize that many patient encounters are not for the reason posted on the chief complaint, but may be a personal family issue where the family comes to get the perspective from an objective caregiver. We can often help alleviate their pain and offer a sense of peace or resolution by lending an ear and showing compassion.

Having dealt with many families in need, I have concluded that by having an open mind and heart we can often provide more healing than any pharmaceutical agent.

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FUTURE MEETINGS

September 22-25, 2005
62nd Annual Brennemann Memorial Lectures
Sponsored by LAPS
Bahia Hotel
San Diego, California
(310) 540-6240 or email
bcarr@lapedsoc.org
See page 11



November 17-20, 2005
Pediatric Update, 27th Annual Las Vegas Seminars
Hosted by American Academy of Pediatrics,
California Chapters, 1, 2, 3 & 4
Venetian Hotel, Las Vegas Nevada
(310) 540-6240 or email
aapcach2@aol.com

Members in the News



Dr. Paula Whiteman was awarded a Special Achievement Award from the American Academy of Pediatrics for distinguished service and dedication to the mission and goals of the Academy for her work on the Emergency Medicine Committee.

Dr. Leonard Apt, professor of ophthalmology and founding director of the division of pediatric ophthalmology at the Jules Stein Eye Institute at UCLA, was honored at the annual meeting of the American Association for Pediatric Ophthalmology and Strabismus. The meeting was held in March in Orlando, Florida. Dr. Edwin M. Stone, professor of ophthalmology at the University of Iowa, delivered the Leonard Apt Honorary Lecture titled "Practical Aspects of Genetic Testing for Inherited Eye Disease." The American Academy of Pediatrics Ophthalmology Section sponsors the annual Apt Lecture.

Dr. Leonard Apt was also awarded the prestigious S. Rodman Irvin Prize on May 21 at the Clinical and Research Seminar at the Jules Stein Eye Institute at UCLA.

The annual award, established by the department of ophthalmology, recognizes a faculty member whose career activities illustrate the finest in doctor-patient or doctor-student relationships, represent the highest traditions of the medical profession or the vision science community, and exemplifies the individual's dedication to the transmission of knowledge to future generations.

Dr. Kenneth Williams, who was president of the Los Angeles Pediatric Society 1970-1971, was honored with the establishment of the Dr. Kenneth O. Williams Chair at USC/Children's Hospital for Bone and Soft Tissue Tumor Research. The mission of the institute is to find cures for childhood cancers. The chair was established by Mr. & Mrs. William M. Close and Family in appreciation for the compassionate care Dr. Williams provided to the Close family for many years. Dr. Williams will also be honored in the near future with a new wing of the St. John's Well Child Center Clinic to be dedicated as the Dr. Kenneth O. Williams Wing.

Welcome New LAPS Members!

Jeremy Shapiro, Los Angeles

Alicia Briggs, Los Angeles



2005 GENE BLACK SUMMER MEDICAL CAREER PROGRAM IS A HUGE SUCCESS!

Robert Hamilton, M.D., Chair, Gene Black Summer Medical Career Program

Our summer 2005 Gene Black Summer Internship Program is now, as the sports announcers like to say, "in the history books." And another great year it was!! In total 53 high school students, between their junior and senior years, participated in the LA County-wide July program. As they followed us in our daily routines, students were allowed the opportunity to intimately "peek behind the curtain" of our profession and see what we really do as pediatricians. The response from our students and our program mentors was overwhelmingly positive. The Gene Black Program continues to be an excellent vehicle for introducing young adults to our profession.

My commitment to this worthy program has never been greater. Here's why: First, the value to our students who participate is great. As one would expect, most of our students have only a vague idea of what medicine really entails even though they profess to have an abiding interest in becoming physicians or nurses. The Gene Black Program shows them the real thing, unvarnished and stripped of the Hollywood glamour. Participation in the program helps to clarify their vision and gives them a sense of reality that helps in their decision making in the years to come.

Second, as a mentor in the program, it is exhilarating to spend a summer month with excited, interested and motivated young people. There are many remarkable young people in our community and the Gene Black Program allows us the wonderful chance to work with the best.

Finally, the opportunity to teach, even at this elementary level, is stretching. Rethinking differentials and explaining disease processes in simple terms moves one beyond the usual work-a-day paradigms. I find this impartation of knowledge to our students exciting and as I participate, I am again challenged personally to continue my efforts to be a student of our profession.

For those interested in participating in the Summer Gene Black Program as a mentor for summer 2006, please contact Robert Hamilton, M.D. at (310) 264-2100.



"This program was an unforgettable experience."





"I have learned so much from all of these amazing physicians and they have inspired me to pursue my medical career."



"They taught me that you don't need to be a genius to become a doctor, you just need to be hard-working, dedicated, and have passion for what you are doing."



"I am more grateful and fortunate to have loving parents and a shelter that may keep me from violence."





"This unforgettable experience has made me more excited about what the future may hold for me."

More Effective Screening for Critical Cardiac Disease in the Newborn

William R. Vincent, M.D.

I suspect that every pediatrician knows the value of very early detection of critical cardiovascular malformations (CCVM) in the neonate. The outcome of surgical treatment, both in terms of morbidity and mortality, is much better if diagnosis is made prior to the infant developing congestive heart failure or severe acidosis. But did you know that the screening the newborn population for CCVM could be improved by a simple, cost-effective measure?

Critical cardiovascular malformations such as hypoplastic left heart syndrome, severe coarctation of the aorta, transposition of the great arteries, Tetralogy of Fallot, pulmonary artresia and total anomalous pulmonary venous return account for about 25% of all congenital heart disease, or approximately 2/1000 births. These infants are all dependent upon continued patency of the ductus arteriosus for short-term stability. Some of these babies are stable and may appear normal while the ductus remains open.

In fact it is the stable appearance and lack of symptoms in these infants in the first hours of life that leads to incomplete detection of cardiac disease prior to discharge from the hospital. Careful physical examination soon after birth can fail to detect these severe malformations as often as 50% of the time[(1)]. Something else is needed to improve our ability to detect these babies and institute prostaglandin infusion while they are still physiologically stable. That something else is pulse oximeter saturation measurement, adding the oxygen saturation value as a fifth vital sign if you will.

A recent study has clearly shown that routine pulse oximeter testing of all asymptomatic newborns prior to discharge can improve detection of those infants with CCVM[(2)]. The normal newborn has achieved an oximeter saturation value of 96% or above by 24 hours of age. If the pulse oximeter value after 24 hours of life remains below 96% there should be a high index of suspicion of CCVM. These infants should receive an evaluation of cardiac anatomy and function prior to discharge. If the baby has a transitional saturation value and no cardiac abnormality the family can be readily reassured prior to discharge.

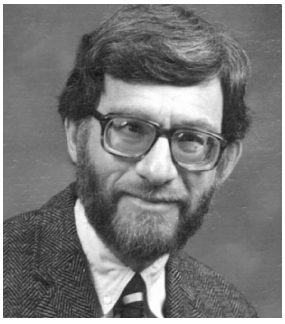
A screening program to detect CCVM is directed at all asymptomatic term infants and employs a single pulse oximeter measurement on a lower extremity done beyond 24 hours of age and prior to discharge from the nursery. This type of screening is now in place in the Northeast in approximately 20 community hospitals with an active newborn service. It has also been started in two hospitals in Southern California. As expected, in those communities with active antenatal screening for fetal cardiac anomalies, the case detection of undiagnosed babies at birth is significantly less than in communities with less vigorous prenatal screening.

The cost of screening is minimal, involving equipment already available in the hospital. Newer oximeter technology allows greater ease and stability of measurement, reducing the time required for each test. The use of cleanable and reusable oximeter probes further decreases the cost of screening to the hospital. A computer tracking system to insure that each patient's pre-discharge saturation value and any appropriate cardiac evaluation are recorded is essential.

Neonates with cyanosis, cardiovascular instability or tachypnea will quickly come to the attention of the pediatrician or neonatalogist, and timely diagnosis of CCVM in this group is not a problem. It is the asymptomatic newborn with CCVM that poses the challenge, and the challenge can be met.

2005 BRENNEMANN MEMORIAL LECTURES

Marshall G. Goldberg, M.D., FAAP, FAAAA&I, Program Chairman

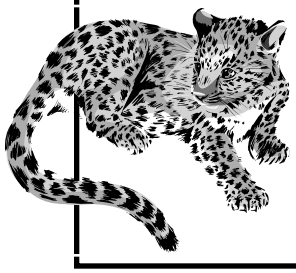


The Bahia Resort Hotel on San Diego's Mission Bay is once again the site. September 22-25 are the dates. We have another All-Star faculty. If we hold it, you will come (to paraphrase a line from Field of Dreams). The stellar cast of speakers consists of Angela Andersom, M.D. (toxicology, poisonings, emergencies), William A. Lutin, M.D., PhD. (cardiology with really great clinically useful topics), Larry K. Pickering, M.D. (infectious disease, vaccines), Frank R. Sinatra, M.D. (gastroenterology presented in a tuneful fashion), and Barry Zuckerman, M.D. (behavioral and developmental issues). In addition Dr. Pickering will present the Clifford Rubin Keynote Lecturship, addressing vaccine controversies. On Friday, September 23, the San Diego Zoo excursion will be available. This is a great outing for the entire family capped by a terrific dinner at the Zoo. We honestly think this is the best three day meeting on the West Coast. We'd love to see you all attend.

FREE MEMBERSHIP

Free membership in LAPS until June 30, 2006 to all third-year pediatric residents graduating this June, 2005. Our gift to you. Just fill out the application on page 11 or at www.lapedsoc.org and return to PO Box 4128 Torrance, CA 90510-4198 or fax to (310) 543-2375.

THE LOS ANGELES PEDIATRIC SOCIETY
Presents the





62nd ANNUAL BRENNEMANN MEMORIAL LECTURES

September 22-25, 2005

BAHIA HOTEL
on San Diego's Mission Bay
998 W. Mission Bay Dr.
San Diego, CA 92109

MEETING INFORMATION
(310) 540-6240 or
e-mail: bcarr@lapedsoc.org
fax: (310) 543-2375

Faculty

ANGELA ANDERSON, MD
Associate Professor of Pediatrics, Brown University Medical School; Attending Physician and Toxicologist, Hasbro Children's Hospital, Providence, Rhode Island.

WILLIAM A. LUTIN, MD
Professor of Pediatrics (Cardiology), Director, Pediatric Cardiac Diagnostic Laboratories and Pediatric Cardiology Fellowship Training Program, Medical College of Georgia, Augusta, Georgia

LARRY K. PICKERING, MD
Senior Advisor to the Director, National Immunization Program, Centers for Disease Control and Prevention, Atlanta, Georgia

FRANK R. SINATRA, MD
Professor of Pediatrics, Keck School of Medicine, University of Southern California; Head, Pediatric Gastroenterology, Women's and Children's Hospital, Los Angeles, California

BARRY ZUCKERMAN, MD
Professor of Pediatrics and Public Health at Boston University School of Medicine, and Chief of Pediatrics, University's teaching hospital, Boston, Massachusetts

Accreditation

This activity is offered by a CMA-accredited provider, the Los Angeles Pediatric Society. Physicians attending this course may report up to 15 hours of Category 1 credits toward the California Medical Association's Certificate in Continuing Medical Education and the American Medical Association's Physician's Recognition Award. The California Board of Registered Nursing approved 15 hours of continuing medical education. Provider number CEP11121.

62nd Brennemann Lectures Meeting Advance Registration

Name ..... Date .....

Address .....

City ..... State ..... Zip .....

Phone ( ) ..... Fax ( ) .....

Email .....

Tuition Fee	Before 8/25	After 8/25	
Physicians: Members of LAPS	$500	$550	$_____
Physician Non-members	$550	$600	$_____
Pediatric Residents Hospital:_____	$ 40	$ 60	$_____
Allied Health Personnel *Category:*_____	$250	$300	$_____
Emeritus with LAPS	$125	$175	$_____

***FRIDAY, SEPTEMBER 23, 2005** *San Diego Zoo excursion: Limited to the first 100 people.*
$60.00 adults $40 children (3-11) N/C (2 & under)
No. of adults ____x____ No. of children 3-11 ____x____ 2 & under ___x N/C = $_____

*Must be registered in advance..... **TOTAL...** $_____

Please make checks payable to: Los Angeles Pediatric Society and return to:
P.O. Box 4198 Torrance, CA 90510-4198. ***We regret credit cards cannot be accommodated.***

62nd Brennemann Lectures Hotel Advance Registration

Name .....

Address .....

City ..... State ..... Zip .....

Phone (Please include area code) .....

Number in Party .....

Hotel Accommodations Requested: ____ *Double* ____*Single*

Arrival: Time ..... Date .....

Departure: Time ..... Date .....

Your check or credit card is acceptable in payment.
MasterCard VISA American Express (circle one)

#..... Exp. Date .....

Signature .....

150 rooms are available to registrants at the special rate of $149 per day single or double occupancy plus tax. Part of this fee is commissionable to LAPS. **Note: Special rates will be available only until August 23, 2005 or until all 150 blocked rooms are taken. Once these rooms are taken, regular hotel rates will apply. WE RECOMMEND YOU MAKE RESERVATIONS FAR IN ADVANCE OF THE MEETING.** *The Los Angeles Pediatric Society disclaims any responsibility for hotel arrangements. Please make check payable and send to Bahia Hotel at address listed above. Phone Number: 1-800-288-0770.*

THE GENE BLACK SUMMER MEDICAL CAREER PROGRAM

The Summer Medical Career Program was established by the Los Angeles Pediatric Society in 1969. The purpose of the program is to stimulate high school students to choose careers in the health professions. This is accomplished by providing first hand experience observing doctors, nurses and allied health professionals at work in hospitals and through career guidance provided by counselors at each participating institution. For a period of four weeks students take part in a variety of activities affording direct contact with both the medical staff and patients. They rotate through the various departments in hospital and observe the role of health-care personnel in providing medical services. The program is different at every location and is usually tailored to meet the interests of the participants.

A weekly stipend of $75.00 is given each student to cover incidental expenses and a certificate of completion at the end of the program. In addition two $500 scholarships are awarded each year from the Edward M. Rissman Scholarship Fund.

Funding is provided by contributions from individuals and groups, Medical Careers Unlimited Medical Group Members and our new Circle of Friends and Donors. To show our appreciation, contributions received this year are listed below. All are cordially invited to join. You will help students get started in the right direction just as perhaps someone helped you.

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E. David Weinstein
Shirley and Irv Whiteman
Lillie M. Williams

2005 Hospitals

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Childrens Hospital Los Angeles
Harbor-UCLA Medical Center, Torrance
Huntington Memorial Hospital, Pasadena
Kaiser Foundation Hospital, Harbor City
King/Drew Medical Center, Los Angeles
LAC/USC Medical Center, Los Angeles
Olive View Medical Center, Sylmar
Santa Monica Hospital, Santa Monica
St. Mary Medical Center, Long Beach
Tarzana Medical Center, Tarzana
UCLA Medical Center, Los Angeles
White Memorial Medical Center, Los Angeles

We regret the omission of any names. If you find an error, please call our office and we will print a correction in the next issue.

The Gift of Listening

William R. Vincent, MD, Pasadena, CA

Daniel was a full-term newborn infant who appeared perfectly formed and healthy at birth, but then septic shock due to group B streptococcal infection promptly developed. As he became critically ill with rapidly deteriorating lung function, he was referred for extracorporeal membrane oxygenation (ECMO) therapy. I met Daniel and his parents to evaluate him for possible underlying cardiac disease, which he did not have. After that point I no longer had any official role in his care.

I saw the parents and the infant intermittently during the next few weeks, as Daniel went through a prolonged period of receiving ECMO. When he was finally removed from the circuit, he initially appeared stable, but it soon became apparent that he had survived the shock episode only to have necrotizing bronchiolitis develop with progressive air trapping and a steadily worsening pulmonary status. Every effort to support him failed to alleviate severe pulmonary hyperinflation. Despite total parenteral nutrition, he had become a frail, emaciated, 1-month-old child who was slowly dying of respiratory insufficiency.

As I spoke with them I had a strong desire to help … but I did not know how.

One day while walking through the neonatal intensive care unit, I stopped to speak with his parents and offer whatever comfort I could. Daniel's mother and father spent hours each day at the bedside of their child and hours more at home focused on his illness and his need to recover. The picture I saw told me clearly that the death of this child was imminent and unpreventable—and that his parents were completely unprepared for this eventuality. Indeed, all of their energies were directed at supporting him and exhorting him to get well. As I spoke with them I had a strong desire to help … but I did not know how.

A thought occurred to me that I initially rejected as inappropriate to my role or training, but because the thought had come to me in response to a desire to help, I re-examined it. I decided to trust it and act on it. I asked Daniel's parents if they had been in communication with their baby, and they both replied that they spoke to him constantly. I then asked them if they had been listening to him, if they had been open to the possibility that he might have something he needed to tell them. They both responded that they had not considered this possibility but expressed an openness to try.

Two days later Daniel's mom told me that she had become very still and listened and had become peaceful over her child's critical status for the first time, but that she had received no specific message from Daniel. Daniel's father told me that he had received a simple but clear message from his child: "I'm O.K." He felt certain of the message and its source. He understood this to mean that his baby would recover. I asked them to continue to listen to Daniel over the next few days.

Daniel's mother received nothing specific, but his father had a second message. This time he clearly received: "There isn't much time." He was confused and upset and told me he apparently had not gotten the first message right. I asked him to consider the possibility that both communications were correct, that Daniel was letting his parents know that he was dying .... and that he was O.K. With understandable reluctance both parents agreed to go along with this interpretation for a time to see what happened. Out of this opening they began to focus on the possibility that their child was dying and needed their permission, their acceptance of his leaving in order for him to go.

Several days later Daniel's parents were at home at about mid-

His parents had a profound sense of peace and in every way seemed to complete their grieving for their child soon after his death.

night, and after a deep examination of their feelings, both realized that they had been holding on to their child's survival as the only acceptable result for them. In that moment they jointly told their son that whatever he had to do, he had their full acceptance and support. Daniel died about 20 minutes later.

The gift of this experience became apparent following Daniel's death. His parents had a profound sense of peace and in every way seemed to complete their grieving for their child soon after his death. It is now seven years later. Over this period I have had many occasions to talk with this family, and on each occasion I have been impressed with the enduring gift of the conversation that occurred between us. I have also wondered who received the greatest gift from this wonderful exchange.

LAPS NEWSLETTER SUBMISSIONS

Here's your chance to express your ideas and opinions to fellow LAPS members. Submit articles of interest to other health professionals to LAPS, PO Box 4198, Torrance CA 90510-4198 or by email to bcarr@lapedsoc.org. Deadline for submission for the September 2005 issue is July 30. For more information, call Barbara Carr at (310) 540-6240.



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The Los Angeles Pediatric Society has established the Dr. Jim Seidel Memorial Fund in support of the Gene Black Summer Medical Career Program. Once the goal of $25,000.00 is reached, we will issue a Dr. Jim Seidel Memorial Scholarship to one student in this program each summer. Selection of the student will be based on Hospital Counselor recommendations and the student's essay about their experience in the program.

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Be Aware: Infant Abandonment and Emergency Department Response

Paula J. Whiteman, MD, FACEP, Co-Chair Committee on Pediatric Emergency Medicine

This article was written at the request of the Los Angeles County Inter-Agency Council on Child Abuse and Neglect (ICAN) Child Death Review Team to help educate Emergency Physicians about the maternal aspect of infant abandonment and was previously published in Lifeline*, the newsletter for the American College of Emergency Physicians, California Chapter.*

Case #1

A 22-year-old female presented to the Emergency Department (ED) complaining of severe vaginal bleeding. The patient was asked about prior history of sexual intercourse, which she adamantly denied. At first the patient refused to have a pelvic exam, but eventually she consented. The ED physician found tears in the vaginal area, which the patient then said were the result of a sexual assault. After an ultrasound revealed an enlarged uterus, the patient was confronted and finally admitted to having given birth. She was evasive about the whereabouts of the baby.

The ED physician persuaded the patient to confide in her mother, who she then called. The patient's mother found the presumably dead baby in the house, which she swaddled in towels and placed in a duffel bag. After driving to the hospital, the patient's mother left the bag in the car in the hospital parking lot while she went in to see her daughter and speak with the ED physician. The ED physician advised the family that if the baby was dead they might need an attorney to defend the patient against possible murder charges, and he suggested the family consider burying the baby and destroying the evidence. While in the hospital, the patient's mother called a family friend who came to the hospital, retrieved the duffel bag and tossed it into a dumpster.

A nurse read the doctor's notes, which stated that the baby had been buried locally and called the police department. After questioning the patient's family friend, the authorities retrieved the dead infant and an autopsy revealed that the baby died from asphyxia, which was ruled to be a homicide by the coroner. At trial however, the defense alleged that the baby had died from choking on amniotic fluid and the mother was convicted of involuntary manslaughter instead of first-degree murder.

The doctor claimed that he had not directed the family to hide the baby, but only that told them to consider all their options.

Case #2

A 25-year-old woman was brought to the ED complaining of abdominal pain and vaginal bleeding. The patient's father initially noticed blood in the bathroom and when asked, the mother told her parents that she had had a miscarriage, the contents of which she placed in a detergent box. At 250 pounds, it had not been obvious that the patient was pregnant. Her family let her call a friend to take her to the ED and they placed the detergent box with her in the car. The woman convinced her friend to let her keep the box in the car while she went in to be examined claiming that she did not want them to know that she had the miscarriage since she might get in trouble for using drugs.

On exam, the ED physician felt that the patient had delivered a baby and that the baby was at term. He then admitted the patient and contacted the hospital social worker. The patient was discharged from the hospital the next day.

Meanwhile, the patient's friend remembered the box in the car and brought it to the hospital thinking it would help with her friend's medical treatment. When the box was opened, twin infants were found dead and law enforcement was contacted. Both babies were determined to have been alive at birth and tested positive for methamphetamines.

The patient was charged with substance abuse, neglect, and possibly homicide for asphyxiation of the newborns. The ED physician was questioned as to why law enforcement had not been called earlier.

Discussion:

When examining the patient with vaginal bleeding, it is important to consider the possibility of a recently delivered infant as part of the differential. The history in these cases was not immediately forthcoming, however, physical exams suggested recent childbirth.

One of the indicators of a recent full term delivery is the size and position of the patient's uterus; it will be at the level of the umbilicus following childbirth as opposed to a first trimester miscarriage when the uterus may still be near the level of the symphysis pubis. Also a pelvic exam will reveal that the cervix has thinned from its dilation to 10 cm to accommodate delivery of the baby; whereas the cervix does not appear thinned after a first trimester miscarriage as there is no associated dilatation. In addition, there may be evidence of vaginal or cervical laceration following a delivery.

While both these doctors made the correct diagnosis, they did not follow an appropriate course of action. Physicians are mandated by law to report suspected child abuse and neglect. If a patient appears to have recently delivered and does not present with an infant, it is imperative to call law enforcement and request further investigation. If the notification is timely, children may be recovered while they are still alive. If the baby is later found deceased, the patient may be charged with homicide with intent to kill a child which is an offense that carries a sentence of 25 years to life.

In both of these cases the infants were as close as the hospital parking lot. In other cases, infants are sometimes found back at the mother's residence hidden in a box or wastebasket.

These mothers are at risk for repeating the act of infant dumping during a subsequent pregnancy, so counseling is also recommended.

These cases were reviewed by the Los Angeles County Inter-Agency Council on Child Abuse and Neglect (ICAN) Child Death Review Team. The ICAN Child Death Review Team is a multi-agency, multi-disciplinary team of professionals who review child deaths from various causes, with an emphasis on reviewing child deaths involving caretaker abuse and/or neglect. Team members include Coroner/Medical Examiner, health professionals, law enforcement, district attorney, county counsel, social services, health services, EMS personnel and others. The Team meets regularly to review child deaths in hopes of improving system responses and enhancing prevention efforts. The Team also produces an annual report on child deaths in Los Angeles County. For more information, please contact the ICAN office at (626) 455-4585, email: tiltod@dcfs.co.la.ca.us. Team meetings are confidential and the identities of these parties cannot be disclosed. In an effort to prevent such tragedies, emergency physicians should consider the possibility of recent childbirth when evaluating patients with a complaint of vaginal bleeding. If recent childbirth is suspected, then this concern should be passed on to law enforcement officials. Hospitals may need to develop protocols involving a multi-disciplinary approach between nursing, Emergency Medicine, Obstetrics and Social Services.

I would like to thank Edie Shulman of the ICAN team for her help with the preparation of this article.

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