



Departmental News

Department of Pediatrics ~ LSUMC New Orleans

KUDOS CORNER



Costa Dimitriades, MD

Costa Dimitriades, MD was promoted to director of Children's Hospital's Pediatric Intensive Care Unit back in July after Steve Levine, MD stepped down after 28 years as head of the PICU. Dr. Dimitriades said the PICU is in the process of moving to a national standard of systems-based critical care that began with the design of a new unit that opened at Children's Hospital this summer. The 9,456-square-foot PICU features cutting-edge technology in 18 private patient rooms. Dr. Levine said, "The unit couldn't be in any better hands. Dr. Dimitriades has got a great affinity for critical care medicine and aside from the medicine, he's a very caring person. The unit is growing under his leadership."

NEW ORLEANS MAGAZINE: TOP DOCTORS 2009

Seventeen Pediatrics faculty members were listed as Top Doctors in New Orleans Magazine's annual list of best local physicians. One of the seventeen, **Cleveland Moore, MD**, was featured in a special article titled "Breathing Easily" which acknowledges Dr. Moore's medical interests and his ties to New Orleans. The article is printed on the last page of this newsletter.

Using the services of Best Doctors, Inc., a Boston-based organization for gathering professional peer ratings, the magazine names the following as among the best in their specialty:

Allergy & Immunology

Cleveland Moore
Ricardo Sorensen

Endocrinology and Metabolism

Alfonso Vargas

Pediatric Allergy & Immunology

Cleveland Moore
Ricardo Sorensen

Pediatric Cardiology

Robert Ascutto
Nancy Ross-Ascutto
Aluizio Stopa

Pediatric Gastroenterology

Raynorda Brown

Pediatric Hematology/Oncology

Renee Gardner
Tammulla Singleton
Maria Velez
Lolie Yu

Pediatric Nephrology

V. Matti Vehaskari

Pediatric Rheumatology

Abraham Gedalia

Pediatric Specialist/ Neonatal-Perinatal Medicine

Brian Barkemeyer
Staci Olistter
Duna Penn
Dana Rivera

ALSO IN THE NEWS...



WWL-TV interviewed **Jaime Morales, MD**, Assistant Professor, Hematology-Oncology, for a story about a Louisiana camp for children with cancer closing its doors after nearly a dozen children got flu-like symptoms. The story ran on WWL-TV's Eyewitness News at 9PM and 10PM on August 2.

WELCOME TO NEW FACULTY

Jessica Mouledoux, MD joined the Hospitalist Division in August as an Assistant Professor of Clinical Pediatrics. She recently moved from Baltimore where she completed her Pediatric Residency at Johns Hopkins Hospital. She received her medical degree from LSU in 2006. Welcome aboard, Dr. Mouledoux!

Erin Pratt, MD, who recently graduated from the Pediatric Residency program, is now an Assistant Professor of Clinical Pediatrics for the Division of Neonatology. She was hired in August as a general pediatrician and will be stationed in the LSU Interim Hospital NICU/Nursery. Congratulations, Dr. Pratt!

LABOR DAY HOLIDAY

Administrative offices will be closed on Monday, September 7 in observation of Labor Day.

UPCOMING EVENTS

September 7	Labor Day Holiday
September 18	Faculty Meeting, Auditorium
October 16	Faculty Meeting, Auditorium
November 13	4 th Annual Jeffrey Model Foundation Symposium, Harrah's Hotel
December 11	Faculty Meeting, Tower 2 Center

SEPTEMBER SUBMISSIONS

Please send your submissions for the next issue of the newsletter to Kelly Allerton. You can reach Kelly by telephone (896-9800), fax (896-2720), or email (kslumb@lsuhsc.edu).

EMPLOYEE ADDRESS UPDATE



Have you moved recently? If so, and your address is different from the address on your pay stub, please complete the Personal Data Change form which is attached to the Newsletter email and give to Owen Allen.

SOUTHERN REGIONAL MEETINGS 2010: CALL FOR ABSTRACTS

The deadline to submit abstracts for the Southern Regional Meetings is October 16, 2009. The meetings will take place at the Hotel InterContinental on February 25-27, 2010. For more information on abstract submission, visit www.afmr.org/sr.cgi.

PUBLICATIONS

An article written by **Yves Lacassie, MD** and **Robin McGoey, MD** has been accepted for publication in the *American Journal of Medical Genetics*. The article is titled "Paternal constitutional balanced reciprocal translocation t(9;22)(q34.3;q11.2) resulting in a liveborn offspring with combined features of both the 9q subtelomere and the 22q11 deletion syndromes due to 3:1 meiotic segregation and tertiary monosomy."

Dr. Lacassie will also have a letter to the editor published in September. "Comments on the 'Genotype First Diagnosis' Controversy" will be published in *Genetics in Medicine*. It is an important debate and one that Dr. Lacassie wanted to share with all faculty, fellows, residents and students. You will find the letter along with an introduction from Dr. Lacassie on the next page.

In the *New England Journal of Medicine* (359:1685-1699, 2008), Mefford et al. published an article about recurrent rearrangements of chromosome 1q21.1 and variable pediatric phenotypes. An accompanying editorial about cytogenetic technology by Dr. David Ledbetter, a distinguished Ph.D. geneticist and Chairman of Genetics at Emory, suggested that in patients with developmental disabilities, microarrays be performed by the primary care pediatricians even before the evaluation by a clinical geneticist. This "genotype first" diagnostic approach, rather than the classic "phenotype first" approach for the diagnosis and delineation of new syndromes, is also promoted by other groups or laboratories offering microarrays. In a letter to the Editor of *Genetics in Medicine* (GIM), Drs. Robert Saul and John Moeschler commented on the importance of a good clinical evaluation prior to and instead of requesting aCGH as a first step. This practice would avoid overuse and misuse of this good but expensive technique especially considering that still most diagnoses are clinical. This letter and the response by Dr. Ledbetter (GIM May 2009) immediately motivated the following letter by Dr. Lacassie which was published in GIM this month. Because its importance for our pediatric community, especially residents and students and the important cost involved for Children's Hospital, we have decided to include the whole text with Dr. Lacassie's personal opinion.

Comments on the "genotype first diagnosis" controversy

To the Editor:

I read with great interest the two letters about the pros and cons of the "Genotype First Diagnosis" announced in the front page of the May 2009 issue of *Genetics in Medicine*.^{1,2} I cannot agree more with Drs. Saul and Moeschler.¹ Although the new technologies, mainly microarray-based comparative genomic hybridization, have significantly increased the number of patients for whom we establish a diagnosis,² there is no question that a good clinical evaluation is still of utmost importance.

The promotion of "testing first" is attractive to many primary care physicians (general pediatricians and some subspecialists) who hope that an abnormal result will provide the diagnosis. The testing first is an example of the "sampling the universe" diagnostic approach described by the late Frank A. Oski.³ This approach is commonly practiced by young physicians. Instead of the use of "hypothesis generation" as the diagnostic method recommended by Oski, and used by most clinical geneticists, a growing number of physicians rely on testing for their diagnoses.

I believe this policy of testing first should not be endorsed by the American College of Medical Genetics (ACMG). It is not an appropriate medical practice, because it increases the cost of medicine, and there are many results that will still need the interpretation of the geneticist and genetic counselor and the evaluation of the family. The attempt to end the "family's diagnostic odyssey" through indiscriminate testing no doubt has a high cost. The number of cases where microarray has been requested by the referring physician before a genetics evaluation is increasing. Furthermore, a significant number of such patients are referred with normal microarray results. By comparison, when a patient has undergone a comprehensive evaluation, including a detailed history and physical examination, microarray seems to yield a higher rate of abnormalities (Lacassie Y, Myrtle V, Sathyamoorthi S, unpublished study).

There is no doubt that our primary goal as physicians is to serve our patients' best interests. In that pursuit, an accurate diagnosis is the cornerstone. In a testing-first approach to genetics, we deemphasize the importance of the family evaluation and phenotype. We may perform unnecessary testing with a consequent high expense. When the diagnostic approach combines clinical skills with the appropriate medical test, the sensitivity of the test is certain to increase. In the case of microar-

ray, it seems clear that the appropriateness of testing is best gauged by a clinical geneticist.

There is also no doubt that there is a "critical shortage" of medical geneticists, as noted by Dr. Ledbetter. More specifically, however, the shortage may reflect the declining number of clinical geneticists. Such a trend will undoubtedly continue so long as molecular testing advances in its diagnostic ability. However, I would like to point out that the major reason why I am commenting on this controversy is the lack of challenge for the clinical geneticist. The evaluation of patients with an unknown diagnosis is challenging, constitutes clinical research, and is intellectually gratifying when your diagnostic hypothesis is confirmed through a specific test. This is why many geneticists enjoy their job. Otherwise dealing with patients with multiple congenital anomalies, mental retardation, or other developmental issues, for which there are few treatments to offer, other than counseling, is not compelling at all to most physicians and medical students.

I openly admit to the referring physicians that I prefer to evaluate the patient without a diagnosis and before any testing. What makes our specialty interesting is the challenge to try to establish an etiological diagnosis.^{4,5} Most geneticist will agree that it is quite disappointing when the patient is referred for evaluation and counseling after the diagnosis was already established. Certainly, the ACMG should be the center of discussion for this topic. Before reading these two letters,^{1,2} I proposed some aspects of this subject to discuss at the next meeting of the ACMG in New Mexico.

Yves Lacassie, MD, FACMG

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Children's Hospital, New Orleans, Los Angeles.
Disclosure: The author declares no conflict of interest.

REFERENCES

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3. Oski FA. Diagnostic Process. In McMillan JA, DeAngelis CD, Felgin RD, Warshaw JB, editors. *Oski's pediatrics: principles and practice*. Philadelphia, PA: Lippincott Williams & Wilkins, 1999, Chapter 10.
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Breathing Easily

CLEVELAND MOORE ALLERGY/IMMUNOLOGY

By Carrie Marks
New Orleans Magazine
August 2009



Dr. Cleveland Moore's interest in allergy and immunology "developed naturally," he says, as a result of "caring for very sick allergic patients." When working in an immunology research laboratory as an undergraduate at the University of California at Berkeley, he first found himself called to the particular specialty. "My interests in medical parasitology and human defense mechanisms led to the practice of medicine," he explains. At the age of 22, he decided to officially pursue a career as a doctor; he was the first member of his family to do so. Although raised in New Orleans, Moore found himself on the West Coast for the completion of both his undergraduate degree and his medical degree, at the Stanford University School of Medicine. Despite having practiced in numerous locations – including New York, Mobile and Nashville – he ultimately felt himself called back to the Crescent City. "I have family here," he says simply. "It's home."

As an allergist, Moore specializes in "a range of disorders." Some of them are basic, like food allergies and

asthma; others are more rare, such as severe combined immune deficiency syndrome or "boy in the bubble syndrome." "My interests lie in hypersensitivity, or allergic disorders found in this field," says Moore. "I am especially interested in allergic disorders that involve the skin, such as atopic dermatitis and eczema, urticaria and angioedema, or allergic hives and swelling." His training allows him to successfully treat these uncomfortable situations, but he also works to manage disorders that defy the more common remedies. Sometimes, he explains, these illnesses are resistant to steroids and alternative treatments must be explored in order to find a cure.

Moore also works to find relief for patients that suffer from severe asthma. According to his experiences in the field, "the challenge in asthma management has to do with the recognition and treatment of subsets in patients." Asthma sufferers may all have the typical symptoms of wheezing and coughing, but their disorders are unique from one another and "do not always respond to the same medications." He states that the

specific challenge of dealing with these patients is "to develop rapid and easy to perform tests that will differentiate between the different types of asthma." Moore has to often explore different options and alternative routes for the asthma patient to achieve optimal health, much like he does for those patients afflicted with food allergies and conditions like atopic dermatitis.

Moore was also in New Orleans to face the challenge of Hurricane Katrina. "We lost our hospitals at Louisiana State University," he remembers, "and our patient population, as well as many specialists." Despite the dismal environment, Moore and the rest of the faculty worked hard to provide the necessary information and education to medical students. "Our challenge was to continue training student physicians in spite of our situation," he says. "We had to rapidly develop alternate sites to train our physicians such that the quality of training and the reduced numbers of patients did not impair training." The hard work yielded results, and Moore is still teaching and practicing in the city of New Orleans.