Academic Newsletter
January 2013

Adolescent Medicine

Adolescent Medicine is a three-person Division that is being lead by Dr. Natasha Johnson. The main areas of clinical service are the McMaster Children's Hospital Eating Disorder Program and the General Adolescent Medicine Service, which serves teens with a wide variety of, often, complicated issues.

We have chosen to focus on Eating Disorders (ED) as the theme for this newsletter, as a new specialized intensive Eating Disorder Program is opening this month in a new space.

McMaster Children’s Hospital Eating Disorder Program:

What started as a one-person program over 10 years ago has grown into a busy, multidisciplinary program. There are three Adolescent Medicine Specialists (Drs. Findlay, Grant and Johnson) and a large interdisciplinary team with over 25 members including child psychiatry (Dr. Jennifer Couturier), psychology, social work, a dietitian, a nurse practitioner, nursing, and child life. The ED service has the busiest outpatient program in Ontario with over 3,500 visits per year. Although an unfunded inpatient service has been offered for over a decade, recent funding from the MOH has allowed the service to open a specialized inpatient unit with six inpatient beds and four day treatment spaces. It is with great enthusiasm that a new purpose-designed unit will be opening on 3B January 28th 2013. This unit will greatly enhance the care provided to children and teens with EDs in our community.

Although this unit is new to McMaster, similar units currently exist in Ottawa, London, and Toronto. The total number of inpatient beds for pediatric EDs in Ontario is now 28 beds. A critical goal in opening this new unit is to reduce the number of teens who are referred out of Canada for intensive services. Over 50 teens with EDs from our program have been sent to out-of-country treatment services over the last five years. We are hopeful that the number of kids unable to access care close to home will be greatly reduced. This will be an area of study for the new program.

Part 2:
3 Things you may not know about Eating Disorders:

1. Restrictive EDs present in childhood: Anorexia Nervosa (AN) and related illnesses are the most common EDs diagnosed in the pediatric age group. Young people typically present with marked weight loss due to severe restriction in caloric intake, over exercise,
self induced emesis or other weight-loss strategies. They are consumed with distorted and intrusive thoughts about the need to lose weight. For those young people who are able to talk about and recognize their symptoms, they reveal how their minds have been “taken over” by this illness and how they don’t understand what is happening to them. In other patients, recognizing or acknowledging symptoms is not easy, often due to a deep sense of shame or embarrassment.

2. Treatment needs to be a family affair:
In the past, an individual approach was used to try to treat AN but, unfortunately, outcomes were poor. Trying to “talk kids out of it” has proven to be an ineffective strategy. Recently, Family Based Therapy (FBT) – has shown improved outcomes in treating AN when it presents in the pediatric age group (Couturier 2013). The fundamental approach used in FBT is that the family is charged with the task of returning their child to health. In order for this to be successful, parents have to understand that they are not to blame for the illness, nor is their child to blame. By taking an agnostic approach to the illness, there is less anger, blame and denial about the symptoms. Another important technique taught to parents and children is “externalizing” of the illness. The ED is viewed as any other illness that occurs, such as diabetes or epilepsy, and thus the child and family have to work together to fight the disorder, reduce the impact the illness has on the child’s life, and prevent long term consequences. This technique allows the child and family to focus on recovery and the task of returning to health, rather than looking for the cause of the eating disorder.

3. The role of the pediatrician:
Given the prevalence of EDs and the limited access to intensive treatment beds in the province, every pediatrician needs an initial approach to management. The Canadian Pediatric Society statement (Findlay 2010) on managing early AN recommends physicians have an understanding of FBT to enable them to give basic advice to families from the time of initial presentation. The most important piece of information to give parents is that they must not back away from feeding their child. This is commonly done by parents (and advised by well meaning physicians) in the hopes that the child will eat more, but it is ineffective and likely to lead to further weight loss. Parents should be counseled to limit exercise and supervise meals and snacks and to impose natural consequences for not eating. A basic example would be: “if you are not well enough to eat, you are not well enough to go to soccer practice.”

Academic Highlights in the Division of Adolescent Medicine

1. National Leadership in Adolescent Medicine:
For the last five years, Dr. Sheri Findlay has played a leadership role at the Royal College of Physicians and Surgeons in the establishment of Adolescent Medicine in Canada. Initially, as Vice-Chair of the Royal College Working Group in Adolescent Medicine, she played a role in gathering the evidence that Adolescent Medicine is a distinct area of pediatric expertise. After becoming an accredited specialty, she transitioned to Vice-Chair of the Specialty Committee and is now Chair-Elect of this committee. She also sits on the Adolescent Medicine Examination Board. In 2012, Dr Findlay was awarded Founder Status by the Royal College in recognition of

Dr. Sheri Findlay
her instrumental work in the creation of a new discipline.

2. **Advances in Education – Pelvic Simulation Project:**
A lot is changing in the area of adolescent sexual health. Worldwide, the initiation of PAP screening is being delayed until women are in their twenties and there are now non-invasive means of screening for sexually transmitted infections (e.g. nucleic acid amplification tests on urine or self-collected vaginal swabs). These changes have led to a decrease in opportunities for pelvic exams. In order to enhance residents’ opportunities to practise this important skill, **Dr. Natasha Johnson** incorporated a pelvic exam simulator into the clinical skills day for pediatric residents in May 2011. A poster summarizing the findings from this novel educational initiative was presented at the Association for Medical Education (AMEE) in Lyon, France as well as at the International Conference on Residency Education (ICRE) in the fall of 2012. Dr. Johnson will continue to study this innovative teaching tool.

![Dr. Natasha Johnson](image1)

3. **Transition: Youth with Chronic Illness Don’t Have to “Fall off the Cliff”:**
**Dr. Christina Grant** is a nationally recognized expert in transition care of youth with chronic illness. Over the last year, she has served as a content expert on the Transition to Adult Healthcare Working Group for the PCMCH and is now representing the CPS in a collaborative project with the Canadian College of Family of Physicians to write a joint statement on Transition Care for Youth with Chronic Illness. This collaboration with adult providers is key in forging a bright future for so many of the patients we all care for. Dr. Grant’s Diabetes Transition Research in collaboration with Dr. Punthakee and Dr. Van Blyderveen continues with success (Grant 2011). This project continues to study different facets of predictors of successful transition to adult care. Posters are presented annually at international venues and a current manuscript is being reviewed with the Journal of Adolescent Health.

![Dr. Christina Grant](image2)

References

