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THE OFFICE OF PEDIATRIC SURGICAL EVALUATION AND INNOVATION

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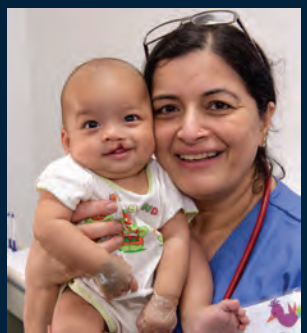
Paediatric Pain



THE OFFICE OF PEDIATRIC SURGICAL EVALUATION AND INNOVATION

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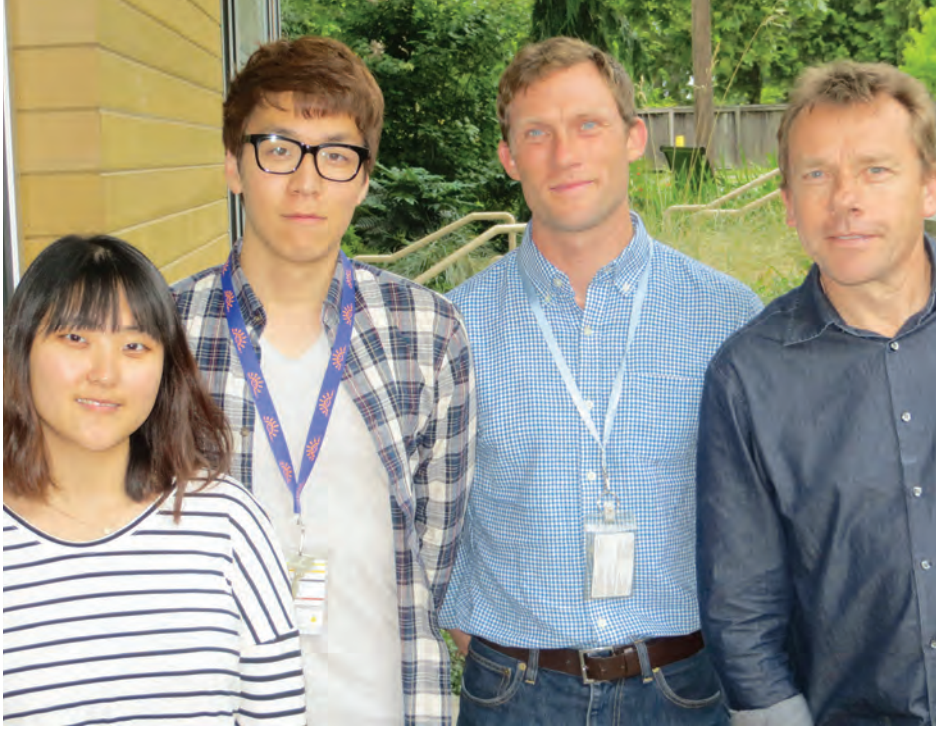
OPSEI NEWSLETTER

DANGER OF NEONATAL HYPOGLYCEMIA

By: Mr. Jon Kim Ms. Rachel Jiwon, Mr. Nick West, Dr. Stephan Malherbe, Dr. Norbert Froese, Mr. Nathan O'Hara



Background

Fasting for a procedure might just cause a few tummies to growl for adults, but for newborn babies, the consequences may not be the same; in fact, they might pay a much higher price than you think!

Neonates have lower blood sugar content compared to adults, making small changes in blood sugar level quite high in proportion. Thus, a small drop in blood sugar level while fasting for a procedure may easily lead to hypoglycemia if the blood sugar levels are not carefully monitored. Studies have shown neonatal hypoglycemia causes poor neurological outcomes by damaging the neuronal and glial cells. This could lead to neurological damage causing severe handicap or death. For this reason, Dr. Norbert Froese and Dr. Stephan Malherbe from the Department of Pediatric Anesthesia became interested in collecting data over a six month period to catch the occurrence rate of hypoglycemia in neonates. In this article, we will provide a brief summary of our experiences and findings, here at BC Children's Hospital (BCCH).

Methods

Dr. Froese, the Head of Anesthesia at BCCH, implemented a policy for blood glucose monitoring in infants effective from February 6th, 2014 until August 31st, 2014. All the anesthesiologists were required to measure and record blood glucose levels, times of measurements, and analysis techniques used for fasted infants less than six months of gestational age. "Fasted" was defined as no IV glucose infusion between 2 hours before and immediately prior to anesthetic induction. Starting March 1st, 2014 and onwards, we attempted to get all the elective and emergency procedures. We checked the daily slates for scheduled electives and audited the charts right after the procedures were completed. A list of emergency cases was generated in ORSOS every 2 weeks and the charts were pulled from the Health Records. Each case was given a subject ID and along with their personal identifiable information (ex. MRUN) was kept in a password protected Excel spreadsheet. Then, we recorded and stored the collected data in the Research Electronic Data Capture (REDCap).

Results

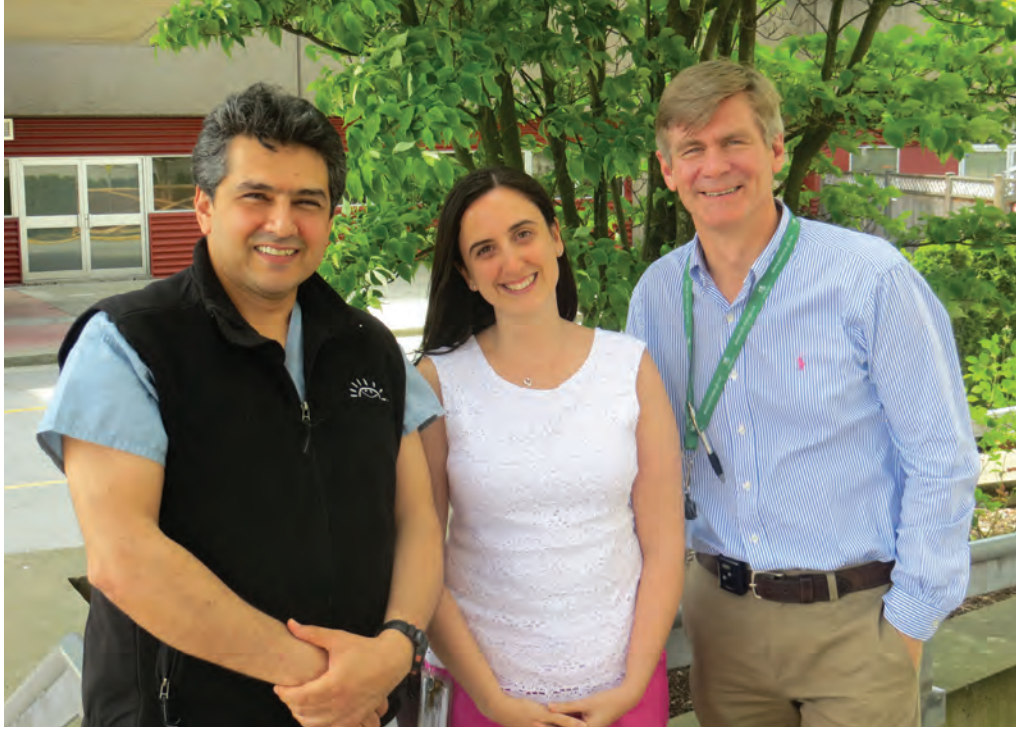
During the time frame of March 1st, 2014 to June 15th, 2014 there were a total of 180 patients under the age of six-months-old who had a procedure. Of the 180 patients, 102 (57%) were fasted, and of those fasted patients, 89 (87%) were term babies and 13 (13%) were premature. Out of all 102 fasted patients, only 2 (2%) had blood sugar value lower than 3.3mmol/L. The average glucose value was 5.9mmol/L with the standard deviation of 1.21mmol/L and the data ranged from 3.0 to 10.4mmol/L.

Conclusion

Fortunately, all the infants were considered to be in a safe blood glucose level range. However, due to the dangers and higher occurrences of hypoglycemia in infants, we are planning to continue with the study until the end of August, 2014 and see what new results we might encounter.

NO STATUS QUO IS PERMITTED: REDEFINING NSQIP AT BC CHILDREN'S HOSPITAL

By: Dr. Erik Skarsgard, Dr. Kourosh Afshar, Ms. Julie Bedford



BC Children's Hospital (BCCH) joined NSQIP-Pediatric in May 2011. From the very beginning, we have had two aims – to develop a culture of safety with all disciplines involved in the care of a surgical patient and to reduce our post-operative complication rates. We decided as our first quality improvement initiative to combine both goals in trying to reduce our urinary tract infection (UTI) rate. We began by developing strong team dynamics and multi-disciplinary relationships with our surgical unit. We used NSQIP data to design a case control study aimed at identifying quality improvement targets. Since starting the UTI initiative in January 2012, we have had significant success in reducing our raw UTI rate from 2% to 0.3%, with no UTIs since September 2013.

Since the spring of 2013, we started to build on our achievement with UTIs by tackling surgical site infections. To succeed in this, we recognize the need to be 'relentless' in our improvement efforts, and have developed a new definition of NSQIP aimed at decreasing complacency in all disciplines – **N**o **S**tatus **Q**uo **I**s **P**ermitted. A variety of activities have sprung from this including increased infection control audits in the surgical suites and updated policies in the OR for attire and patient temperature regulation. Surgical departments have also been tasked with determining at least one quality improvement initiative.

Two specific quality improvement projects have also arisen to address our high SSI rate – an Appendectomy clinical pathway and a Gastroschisis clinical pathway. The Appendectomy pathway standardizes fluid management pre-operatively, antibiotic choice and duration, the need for catheterization, and ultrasound use post-operatively. All medical students, residents and fellows are provided with a laminated card with this pathway for ease of reference and pre-printed order sets have also been developed. The Gastroschisis pathway currently underway examines all aspects of care from delivery of the infant through to discharge. Due to the large scope of this pathway, aspects of this pathway are completed at different rates. Thus far, antibiotic use pre, intra and post-op have been standardized between the Pediatric Surgery Department, Pharmacy and our NICU physicians.

Have ideas or a quality improvement initiative we could assist with? Just let us know – we're more than happy to chat with you!

FROM THE CANADIAN MILITARY TO UGANDA PEDIATRIC SURGERY CAMP: IZZY DOLLS BRING COMFORT AND SMILES TO CHILDREN

By: Mr. Damian J. Duffy

"We were so pleased and excited to know that HPIC would provide us with enough dolls free of charge for all of the children coming for surgery in Soroti and Kampala, Uganda."

Izzy Dolls and Health Partners International of Canada

BC Children's Hospital's Uganda Pediatric Surgery Camp has a partnership with Health Partners International of Canada, who help to supply our essential surgical camp medicines at 8% of the regular cost for medical humanitarian efforts like ours around the world. So in 2013, we were kind of surprised when we opened our shipment of medical supplies to see several beautiful and colourful hand-knitted dolls inside. As part of HPIC's practice, they use the knitted dolls to not only provide filling material for the breakable medicines, they are also included with the essential medicines to bring comfort and care to the children. At that time, there were just a dozen or so dolls in the boxes, so we carried them with us to Uganda Pediatric Surgery Camp. The Izzy Dolls were an immediate hit with the children. So when we started planning for the 2014 Uganda Pediatric Surgery Camp, we wrote to HPIC and asked them what would be involved in organizing an Izzy Comfort Doll for each child receiving care at the camp. We were so pleased and excited to know that HPIC would provide us with enough dolls free of charge for all of the children coming for surgery in Soroti and Kampala, Uganda.

As you can see from the collection of photos, the dolls brought so much joy, comfort, and warmth to this year's surgical camp. The Izzy Dolls were a companion to the children going through surgery, recovery, and then back to the ward. Thank you so much, Health Partners International of Canada and your wonderful team of caring and compassionate knitters!

A Brief History of Izzy Dolls in Canada

We came to learn that the knitted dolls are properly called, "Izzy Dolls" and were named after Master Corporal Mark Isfeld who was killed while serving in the line of duty with the Canadian Armed Forces in Croatia in 1994. While Master Corporal Isfeld was on peacekeeping missions, he noticed that children often

We came to learn that the knitted dolls are properly called, "Izzy Dolls" and were named after Master Corporal Mark Isfeld who was killed while serving in the line of duty with the Canadian Armed Forces in Croatia in 1994. While Master Corporal Isfeld was on peacekeeping missions, he noticed that children often had no toys at all. His mother Carol began knitting dolls, so he could give them out to frightened children as part of his peacekeeping work. Even after his tragic death, the Isfeld family and friends kept up the important work of the knitting and distribution of the Izzy Dolls to poor children in need in war-torn countries.

In 1998, Mrs. Isfeld had partnered with Mrs. Sandra Bast to create Izzy Dolls for African children orphaned by HIV. When Mrs. Isfeld passed away, Mrs. Shirley O'Connell took up the cause to organize the distribution of the dolls. Responding to a need, Mr. Billy Willbond developed a special African comfort doll which were distributed through his charity called ICROSS. By 2007, Izzy African Comfort Dolls had been packed along with medical supplies reaching Nigeria, Malawi, the Democratic Republic of the Congo, Darfur, and Afghanistan. A network of knitters from communities including Steinbach, MB; Perth, Ontario; Victoria, Courtney, BC; Chilliwack, BC; Halifax, NS; Dunnville, Ontario and all across Canada collaborate to provide Izzy Comfort Dolls to children each year. The Mark R. Isfeld Secondary School in Courtenay, British Columbia was officially named on October 22, 2001 to honour his contributions to our country.

Izzy Dolls by the Numbers

- **12 Izzy Dolls are packed in every HPIC Physician Travel Pack full of essential medicines**
- **12,000 Izzy Dolls are required every year to meet the need**
- **Hundreds of knitters from across Canada volunteer to help**
- **Close to 200,000 children have now received Izzy Dolls**
- **Given to children in need in more than 100 countries**

References:

1. IzzyDoll.ca
2. Health Partners International of Canada – HPICanada.ca
3. ReadingandRemembrance.ca
4. Inthemoodforpeace.com – The Story of the Izzy Doll
5. Veterans.gc.ca
6. Youtube.com: The Izzy Doll Song

The Canadian Pediatric Surgery Network
Le Réseau Canadien de Chirurgie Pédiatrique

THE CANADIAN PEDIATRIC SURGERY NETWORK: (CAPSNet)

By: Ms. Irena Zivkovic

CAPSNet is currently involved with several collaborative initiatives, including three database harmonization projects, the Canadian Biliary Atresia Registry (CBAR), the CDH EPIQ study, and the Secondary Analysis Project.

CAPSNet

The Canadian Pediatric Surgery Network (CAPSNet) is a multi-specialty Canadian collaborative established in 2005 to enable systematic study of the two most common structural birth defects encountered by pediatric general surgeons: gastroschisis (GS) and congenital diaphragmatic hernia (CDH). Congenital diaphragmatic hernia and gastroschisis are birth defects that occur at a frequency of 1 in 2200 and 1 in 2500 live births, respectively.

Gastroschisis is a congenital defect of the abdominal wall, leading to protrusion of the fetal intestines outside the abdominal cavity during fetal development. Congenital diaphragmatic hernia (CDH) is a defect in the formation of the diaphragm with protrusion of the fetal abdominal organs into the chest cavity impeding fetal lung development. These two critical birth defects require surgery in the immediate neonatal period due to their severity.

In view of the small number of cases per center, traditional reporting from single institutions has resulted in a lack of consensus on the optimum management and care of these infants. The CAPSNet database serves as a fantastic national benchmarking resource, collecting prenatal and postnatal data on infants with GS and CDH at 17 centers across Canada.

CAPSNet has 30 members, including pediatric surgeons, perinatologists and maternal fetal medicine specialists, and neonatologists. Through collaboration, CAPSNet strives to serve as a national pediatric surgical database that provides identification of variation in clinical practice across Canada. This data will allow for medical professionals to develop new ideas for targeted practice intervention. The network's goal is to encourage collaboration amongst medical professionals and trainees nationwide in order to facilitate national

research endeavors. CAPSNet aims to disseminate new knowledge through effective knowledge translation while studying the economic impact of clinical practice decisions. Now in its 9th year of data collection, the network has published 28 manuscripts and has had 50 conference proceedings at national and international meetings.

CAPSNet is currently involved with several collaborative initiatives, including three database harmonization projects, the Canadian Biliary Atresia Registry (CBAR), the CDH EPIQ study, and the Secondary Analysis Project.

The database harmonization projects are three endeavors that will combine CAPSNet data with other related data sets. These projects include collaborations with investigators from the OSHPD database in California, the birth defects database of the British Association of Pediatric Surgeons (BAPS-CASS), and the Children's Hospitals Neonatal Consortium. Developed by Dr. Rick Schreiber, a pediatric gastroenterologist at BC Children's Hospital, CBAR is modeled after the structure and governance of CAPSNet, and shares much of its data collection infrastructure. CBAR will create a national network and database for biliary atresia to enable outcome studies and identification of best practices for BA.

CAPSNet is working with the Canadian Neonatal Network (CNN) to develop a national, collaborative practice improvement program for congenital diaphragmatic hernia (the CDH EPIQ study). The initiative follows the Evidence Based Practice for Improving Quality (EPIQ) methodology developed by CNN. The study involves 27 neonatologists and pediatric surgeons from across Canada. The Secondary Analysis Project, funded by CIHR, combines CAPSNet data with that of Vital Statistics, exploring the epidemiology of gastroschisis in Canada. Together with Geographic Information System epidemiologists in Toronto, the research team is exploring maternal exposures at the level of household dissemination areas.

CAPSNet is grateful to CIHR, the Canadian Association of Pediatric Surgeons (CAPS), and Dr. Shoo Lee, whose support has enabled the network to continue its work. CAPSNet continues to look towards a future where collaborative effort enables further research using CAPSNet data, a vital source of information for medical professionals nationwide.

OPERATION RAINBOW CANADA (ORC)

By: Ms. Doreen Lore

"The best way to not feel hopeless is to get up and do something. If you go out and make some good things happen, you will fill the world with hope and you will fill yourself with hope." These profound words, spoken by U.S. President Barack Obama, illustrate the approach that is core to volunteers working with Operation Rainbow Canada (ORC).

ORC is a non-profit organization that provides free reconstructive surgery to children and young adults in developing countries. Many of its members work at BC Children's Hospital, including Heather Posno (OR), Rudy Mateo (OR), Caroline Kohlberg (ICU), Andrea Yuel (ICU), Dolly Khanna (NICU), Norma Serka (retired), Doreen Lore (Radiology), Dr. Bob Purdy (Anesthesia), Dr. Jeff Sampson (Anesthesia Fellow), Dr. Naz Bhanji (Pediatrician), and Dr. Jennifer Smitten (Pediatric Resident). These BCCH employees raised money, volunteered their time and donated their skills on the recent medical mission in February 2014 to the Preah Ket Melea Hospital in Phnom Penh, Cambodia.

During the 10-day mission, 247 patients were screened and 124 procedures were performed. The majority of the procedures (65) were for cleft lip and palate.

When asked about their decision to volunteer with ORC, most members state that their number one reason is because of ORC's positive impact on over 2000+ individuals and their families due to the free transforming surgeries.

During missions, team members frequently develop personal connections with patients, despite the short time spent in the host country. In 2014, the successful repair of a unilateral cleft lip in an 8 month old baby abandoned at a Buddhist temple was celebrated by the entire team.

Another patient that touched the team's hearts was a 12-year-old girl named Cleft. Cleft was named during the time of her delivery by the doctor in attendance because she was born with bilateral cleft lip.

Another patient that touched the team's hearts was a 12-year-old girl named Cleft. Cleft was named during the time of her delivery by the doctor in attendance because she was born with bilateral cleft lip. Not only did Cleft have to live with her deformity, she was reminded every time she was spoken to by others. As a result, Cleft did not go to school because they ridiculed her too much. When she first arrived for her screening, she was very sad and avoided all eye contact. After the surgery, her family's number one task was to rename her.

Cambodia is a lovely country and popular with many tourists. It is very easy to forget that it is a country plagued with poverty and a lack of education. The socioeconomic gap between the rich and the poor has been increasing preventing most Cambodian citizens from obtaining equal access to healthcare.

Currently, ORC is working on a project to provide more skills training and education to Cambodian health professional to increase their self-sufficiency. Hopefully, through the continued education and training efforts of Non-Government Organizations such as ORC, Cambodia will one day have enough skilled health professionals to provide much needed surgeries to all citizens. In the meantime, we are thankful that in Canada, we have a great medical system and a volunteer culture that can help others in need.

UNITE FOR SIGHT: SUSTAINABLE EYE HEALTH DELIVERY WITHIN REMOTE GHANAIAN VILLAGES

By: Mr. Damian J. Duffy

Unite for Sight invests human and financial capital to support social ventures aimed at eliminating preventable blindness and improving vision around the world. Unite for Sight applies best practices in eye care, public health, volunteerism, and social entrepreneurship to achieve its goal of high-quality, accessible eye care for all. It has projects in Honduras, India and Ghana where volunteers can come and work with local health care providers.

Last year, I applied to be a Global Impact Fellow and after completing the Unite for Sight online Global Health course, was accepted for a four-week project in Ghana. The Crystal Eye Center and the North Western Eye Clinic are the two local teams in Ghana with whom Unite for Sight partners. The Crystal Eye Center is run by Dr. James Clarke who is an ophthalmologist. Each morning, an ophthalmic nurse, optometrist, and driver came and picked us up in the Unite for Sight van and we went on a village eye health outreach. The outreach clinics are usually run in the village church. The outreach begins with an eye health education talk. There are several stations to streamline the outreach: registration, visual acuity testing, ophthalmic nurse, optometrist, eye drops, eyeglasses, and data entry. On one day in Nzema on the western border of Ghana we saw over 500 patients. It seemed the patient demographics are about 40% pediatric, 40% geriatric, and 20% working adults. The patients moved from station to station with a form which is completed at each station.

Patients who are referred for surgery are clustered by village/region so as to maximize patient transport resources. When the patients come for surgery they are given lodging and meals and then transported home to their villages after post-op follow up.

My role varied from day to day and village to village. I was trained by the ophthalmic nurses on how to test patients at the visual acuity station before going to see the eye doctor. I also helped to manage the flow of patients from station to station, especially the elderly who needed assistance. I also worked at the eyeglass and medication dispensing station which was really fun and educational. I spent a fair bit of time

also at the eye examination table with the ophthalmic nurses and optometrist learning about what an amazing organ the eye is and seeing common eye health problems which can be easily corrected with a 20-minute surgery or a simple pair of reading glasses. The most memorable parts of the Unite for Sight program in Ghana were the remarkable, heroic local health care providers who were so committed to their patients. They truly make the extra effort to selflessly care for the poorest of the poor, including refugees from Liberia and Côte d'Ivoire who are now living Ghana.

It was truly a wonderful, heartwarming experience working with Unite for Sight in Ghana, which I will never forget. I went to learn about sustainable community eye health delivery and ended up learning about international collaboration, compassion, teamwork, joy in adversity, friendship and humanity. Thank you so much, Unite for Sight.

Office of Pediatric Surgical Evaluation and Innovation

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THE OPERATING ROOM ALLOCATION METHODOLOGY: (ORAM)

By: Lenny Zhou, MMOR and
Jugpal Arneja, MD, MBA, FRCSC

What's the best way to allocate OR block time? A data driven approach to departmental "OPERATIONS".

Background

As the only quaternary care facility for children in the province, BC Children's Hospital (BCCH) provides pediatric subspecialized care for the most seriously ill or injured children in British Columbia. As experienced by other hospitals in Canada, timely access to elective surgery has been a great challenge that the Department of Surgery at BCCH has faced. In 2008, the Canadian Pediatric Surgical Wait Times (CPSWT) project established a set of Pediatric Canadian Access Targets for Surgery (P-CATS) with the intention of quantifying a safe wait time for pediatric surgery across Canada based on a specific diagnosis. In order to translate this benchmarked robust data into something meaningful and practical with respect to how we allocate surgical block schedules at an operational level, since 2010, BCCH has adopted the Operating Room Allocation Methodology (ORAM). ORAM was developed by a local Vancouver consulting firm, AnalysisWorks, to allocate operating room (OR) hours, one of the scarcest resources in our healthcare system. The implementation of ORAM in conjunction with a 20% increased OR capacity has resulted in a reduction in our overall surgical waitlist despite growing demand.

Methodology

Unlike the traditional fixed OR schedule prior to October 2010 (*exhibit 1*), OR hours by services are reallocated using ORAM on an every six month basis (*exhibit 2*) based on two factors: the changes in number of patients on a specific service's waitlist as well as wait time performance of completed OR cases.

Each of these factors takes 50% of weight in the calculation. The principle is to reassign OR hours to services in a data-driven way to those specific subspecialties with the most real need. We are now in the 4th year of utilizing this methodology.

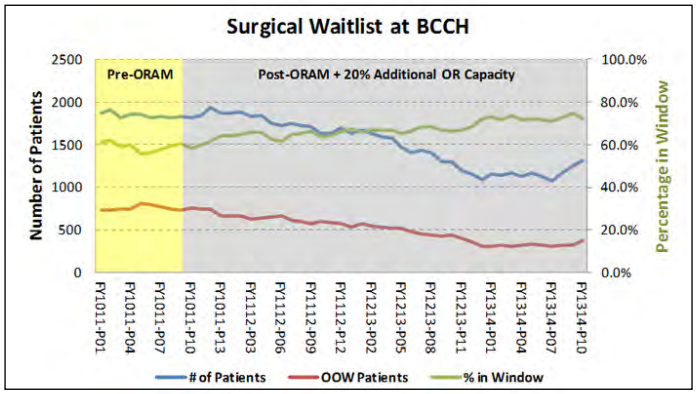

Exhibit 1 - Traditional OR Block Schedule

OR BLOCK SCHEDULE created on Jan 29th, 2009

	Monday	Tuesday	Wednesday	Thursday	Friday
OR#1	Plastics	Neuro Surgery	Plastics	Plastics	Neuro Surgery Neuro Surgery Neuro Surgery (Late Room)
OR#2	Ophthalmology	Ophthalmology Ophthalmology	Ophthalmology Ophthalmology	Ophthalmology (Late Room) Ophthalmology (Late Room)	Ophthalmology
OR#3	General		Cardiac	General	GI GI/MXFZ GI/MXFZ GI GI/MXFZ GI/MXFZ GI/MXFZ GI/MXFZ
OR#4		Cardiac		Cardiac	General
OR#7	Orthopedics (Late Room)	Orthopedics (Late Room)	Orthopedics	Orthopedics	Orthopedics
OR#8	ENT GYNE ENT ENT ENT	ENT	ENT (Late Room)		Orthopedics Orthopedics
OR#9		Urology Dermatology Urology Ophthalmology	Urology Urology	Urology (Late Room) Urology (Late Room) Urology (Late Room)	Urology (Late Room) Urology Urology (Late Room) Urology (Late Room)

Exhibit 2 OR Block Schedule Using ORAM

OR BLOCK SCHEDULE May 2014

MON	TUE	WED	THU	FRI
5 CVS(L) DDS DDS GENL OPTH (OOW) ORTHO(L) PLAS OA	6 CVS(L) DDS ENT NEUR OPTH ORTHO (HIP) (OOW) ORTHO (L) UROL	7 CVS DDS ENT (L) ENT (OOW) GI ORTHO (L) ORTHO (SPINE) (OOW) OA	8 CVS(L) DDS GENL GENL (L) OPTH ORTHO (SPINE) (OOW) PLAS UROL	9 DDS DDS ENT (OOW) GENL (L) GI ORTHO PLAS (OOW) OA
12 CVS(L) DDS DDS ENT (OOW) GENL (L) ORTHO PLAS OA	13 CVS(L) DDS DERM ENT NEUR ORTHO (HIP) (OOW) ORTHO (L) UROL	14 CVS(L) DDS ENT ENT (L) ORTHO ORTHO (SPINE) (OOW) PLAS OA	15 CVS DDS OPTH OPTH (L) ORTHO (L) ORTHO (SPINE) (OOW) PLAS UROL (OOW)	16 DDS ENT (OOW) GENL GI NEUR (L) ORTHO ORTHO (SPINE) (OOW) OA
19 STAT	20 CVS(L) DDS ENT (OOW) NEUR OPTH ORTHO (HIP) (OOW) ORTHO (L) UROL	21 CVS DDS ENT (L) GI ORTHO ORTHO (SPINE) (OOW) PLAS (L) OA	22 CVS(L) DDS GENL GENL ORTHO ORTHO (SPINE) (OOW) PLAS UROL (L)	23 DDS DDS ENT (OOW) GENL (L) GI ORTHO PLAS OA
26 CVS(L) DDS ENT GENL ORTHO (L) PLAS UROL OA	27 CVS DDS ENT (OOW) NEUR OPTH ORTHO (SPINE) (OOW) ORTHO (L) UROL	28 CVS DDS ENT ENT (L) GI ORTHO ORTHO (SPINE) (OOW) OA	29 CVS DDS OPTH OPTH ORTHO (L) ORTHO (SPINE) (OOW) PLAS UROL (L)	30 DDS ENT (OOW) GENL (L) MXFS NEUR ORTHO PLAS (OOW) OA

Results

The waitlist report published by PHSA's Performance Measurement Reporting shows that, compared to April 2010, the number of patients on our waitlist in December 2013 has reduced from 1873 to 1313 patients and the number of patients with wait time greater than the P-CATS target (out-of-window cases) has reduced from 728 to 367 patients, which represents 29.9% and 49.6% of reduction respectively. The percentage of in-window patients has increased from 61.1% to 71.6% (*exhibit 3*).

Conclusions

ORAM is a transparent and data-driven methodology to reallocate OR block time to those services that require elective time the most. Rather than allocating OR time by perceived need or historical apportioning, ORAM is able to provide evidence to identify the true need for each surgical service so that OR hours can be assigned accordingly on a six months basis. Consequently, the overall number of patients on our surgical waitlist has been improving steadily since the implementation of ORAM as well as a by-product of a 20% uptick in overall increased OR capacity.

Acknowledgements

Many innovative and forward-thinking people were involved in the strategy and implementation of ORAM to the BCCH Department of Surgery. Our leadership team would like to express our great appreciation for their efforts. Additionally, much gratitude goes to all of our surgical divisions and their office staff who are always willing to provide feedback and accommodate the new OR block schedule every six months.

Awards & Achievements

Dr. Erin Moon

Congratulations to Dr. Erin Moon, Department of Psychology for your recent publication on Pediatric Pain!

Moon, E.C., & Unruh, A. (2013). The effects of sex and gender on child and adolescent pain. In P.J. McGrath, B. J. Stevens, S. M. Walker, & W. T. Zempsky (Eds.), Oxford textbook of pediatric pain. New York: Oxford University Press.

This chapter reviews recent literature on sex and gender differences in child and adolescent pain. It also includes a discussion of the biological, family, and socio-cultural factors thought to contribute to these sex and gender differences. Support for this work was provided by a post-doctoral fellowship award to Dr. Moon by the BC Children's Hospital Foundation.

Mrs. Bindy Sahota

Congratulations to Mrs. Bindy Sahota 25 Years of Service!

Mrs. Bindy Sahota was recently recognized for her 25 years of service to UBC at the annual 25 Year Club Dinner at the West Atrium of the Life Sciences Centre Building on May 6, 2014. The UBC 25 Year Club was established in 1971 by President Walter Gage to recognize non-faculty staff with 25 years of uninterrupted or accumulated service.

Over the years, the annual dinner has become a wonderful opportunity for new, active and retired members to keep in touch with each other and the university in a warm, celebratory environment.

2014 OPSEI Cup Soccer Tournament Champions:
Brian Page, Michael Barker, Jon Kim, Jack Huebner, Fash Knule, Dustin Dunsmuir (L-R)

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