a little girl,
a lot to teach

WHEN SHE WAS BORN,
DOCTORS GAVE HER A
FEW WEEKS TO LIVE. THAT
WAS SEVEN YEARS AGO.

high-tech helping hands
A SPECIAL ROBOT HELPS
WITH COMPLEX SURGERIES

the anderson pavilion in action
TAKE A LOOK INSIDE OUR
NEW HOME!

a step closer
IMPORTANT ADVANCEMENTS
IN THE FIGHT AGAINST
DRUG-RESISTANT LEUKEMIA

a little girl,
a lot to teach
WHEN SHE WAS BORN,
DOCTORS GAVE HER A
FEW WEEKS TO LIVE. THAT
WAS SEVEN YEARS AGO.

SPRING 2012
our history

Founded in 1901, Children’s Hospital Los Angeles is one of the nation’s leading children’s hospitals and is acknowledged worldwide for its leadership in pediatric and adolescent health. Children’s Hospital Los Angeles is one of only 11 children’s hospitals in the nation, and the only one in California, ranked in all 10 pediatric specialties in the U.S. News & World Report rankings and named to the magazine’s Honor Roll of children’s hospitals.

The Saban Research Institute of Children’s Hospital Los Angeles is one of the few freestanding research centers in the U.S. where scientific inquiry is combined with clinical care and is devoted exclusively to children. The Institute’s investigators hold faculty appointments at the Keck School of Medicine of the University of Southern California and the center is an academic member of the Los Angeles Basin Clinical and Translational Science Institute, an academic-clinical-community consortium.

Children’s Hospital Los Angeles is a premier teaching hospital and has been affiliated with the Keck School of Medicine of the University of Southern California since 1932.
“With the new day comes new strength and new thoughts.”
— Eleanor Roosevelt

I am amazed by the changes happening at Children’s Hospital Los Angeles. As we wrap up the celebration of our 110-year anniversary and honor the rich history of this amazing institution, we are diving headfirst into the future as one of the top children’s hospitals in the country.

Our new mission statement distills the best parts of our past and future down to a simple, succinct message: We create hope and build healthier futures.

Our new home is incredible. The Marion and John E. Anderson Pavilion is everything we hoped it would be and more, allowing our staff to rise to new levels of greatness in the care of the children and families we serve. We have Marion and John Anderson to thank for this, not only because of their generous gift but also for Marion’s tireless work as co-chair of the Board of Trustees and of the Living Proof Campaign. It was hard to say goodbye to John on his passing in July, but his legacy lives on through this building and his countless other good works.

Our new advertising campaign celebrates this wonderful facility and the talented caregivers who work within it. You may have seen our television commercials, billboards, Web and magazine ads that help to spread the word about our ranking as California’s top children’s hospital.

These amazing new changes help spur us on with renewed vigor to take Children’s Hospital Los Angeles to the next level. We are not resting on our laurels. We are constantly looking for ways to improve, because as they say, “The best never rest.”

In the following pages, you’ll see examples of how we’re taking things to the next level—exploring the future of robotic surgery, neonatal telemedicine and cancer research. You’ll also see examples of why we’re the best at what we do. In addition, we present for you the indicators of our financial stability with our annual report for fiscal year 2011, and thank the donors who help make everything possible.

So keep an eye on us. We’ve accomplished great things, and we promise, there are more great things to come.

Sincerely,

Richard D. Cordova, FACHE
President and Chief Executive Officer
Children’s Hospital Los Angeles
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<th>Page</th>
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<td>Statistical Report</td>
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<td>Marion and John E. Anderson</td>
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<td>Pavilion in Action</td>
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<td>Preparing for a Disaster</td>
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<td>On the Fast Track</td>
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<td>High-Tech Helping Hands</td>
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<td>The Doctor is in … Los Angeles</td>
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<td>A Little Girl, A Lot to Teach</td>
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<td>RN Remedies</td>
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<td>Honor Roll of Friends</td>
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<td>Honor Roll of Donors</td>
<td>34</td>
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<tr>
<td>Hospital Leadership</td>
<td>76</td>
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On June 23, 2011, more than 200 community leaders and supporters celebrated the historic dedication of the nation’s most technologically advanced children’s hospital by cutting the ribbon on the new Marion and John E. Anderson Pavilion at Children’s Hospital Los Angeles.

Randall Wetzel, MD, chairman of the Department of Anesthesiology and Critical Care Medicine at Children’s Hospital Los Angeles, organized the “Meaningful Use of Complex Medical Data (MUCMD) Symposium,” held Aug. 26-27, 2011. Representatives from NASA, Harvard, Stanford, the Jet Propulsion Laboratory, Yahoo and Facebook gathered to discuss how best to harness electronic data to enhance the quality of care delivered to patients.

The 25th Annual Nautica Malibu Triathlon, held Sept. 17-18, 2011, raised more than $1 million for Children’s Hospital Los Angeles. Racers raised funds in support of the hospital’s Pediatric Cancer Research Program.

The Leapfrog Group once again named Children’s Hospital Los Angeles to its elite Honor Roll of children’s hospitals. Only 11 children’s hospitals in the United States achieved Honor Roll status for 2011-12, and Children’s Hospital is the only hospital in California to receive the tribute.

U.S. News & World Report once again named Children’s Hospital Los Angeles to its elite Honor Roll of children’s hospitals. Only 11 children’s hospitals in the United States achieved Honor Roll status for 2011-12, and Children’s Hospital is the only hospital in California to receive the tribute.

For the third consecutive year, Children’s Hospital Los Angeles earned the Top Hospital designation from The Leapfrog Group, which annually recognizes the best hospitals in the nation for providing the safest and highest quality health care services to patients.

A team of neonatologists at Children’s Hospital Los Angeles published the first research paper to study the feasibility and safety of a remote-controlled, robotic telemedicine system in the neonatal intensive care unit (NICU).

In June 2011, Pasadena Magazine’s fourth annual “Top Doctors” issue honored 86 staff physicians from Children’s Hospital Los Angeles Medical Group.

On June 23, 2011, more than 200 community leaders and supporters celebrated the historic dedication of the nation’s most technologically advanced children’s hospital by cutting the ribbon on the new Marion and John E. Anderson Pavilion at Children’s Hospital Los Angeles.

Children’s Hospital Los Angeles recently joined the Autism Treatment Network (ATN) as a Center of Clinical Excellence, and is now the only ATN site in California. The ATN is supported by Autism Speaks, North America’s largest autism science and advocacy organization.

On July 17, 2011, Children’s Hospital Los Angeles staff safely transported 191 inpatients into the 317-bed, seven-story Marion and John E. Anderson Pavilion. The process started at 7 a.m. and ended at 3:30 p.m., when the last patient was brought inside the new building.
financial summary

Balance Sheet
As of June 30, 2011 and 2010

(in thousands)

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>$12,685</td>
<td>$4,281</td>
</tr>
<tr>
<td>Accounts receivable, net</td>
<td>60,119</td>
<td>76,485</td>
</tr>
<tr>
<td>Other current assets</td>
<td>84,149</td>
<td>115,400</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>156,953</td>
<td>196,166</td>
</tr>
<tr>
<td>Assets limited as to use, net of current portion</td>
<td>584,186</td>
<td>448,024</td>
</tr>
<tr>
<td>Pledges receivable, net of current portion</td>
<td>55,991</td>
<td>31,409</td>
</tr>
<tr>
<td>Other assets</td>
<td>30,286</td>
<td>25,506</td>
</tr>
<tr>
<td>Property, plant and equipment, net</td>
<td>878,009</td>
<td>798,424</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>$1,705,425</td>
<td>$1,499,529</td>
</tr>
</tbody>
</table>

| LIABILITIES AND NET ASSETS |            |            |
| **Current Liabilities** |            |            |
| Accounts payable and accrued expenses | $46,243 | $41,118    |
| Other current liabilities | 97,013 | 78,379     |
| **Total Current Liabilities** | 143,256 | 119,497    |
| Long-term debt, net of current portion | 487,602 | 490,847    |
| Other noncurrent liabilities | 41,416 | 55,598     |
| **Total Liabilities** | 672,274 | 665,942    |

| **NET ASSETS** |            |            |
| Unrestricted | 735,914 | 579,153    |
| Restricted | 297,237 | 254,434    |
| **Total Net Assets** | 1,033,151 | 833,587    |

**Total Liabilities and Net Assets** | $1,705,425 | $1,499,529
## Statements of Activities
For the years ended June 30, 2011 and 2010

(in thousands)

### REVENUES

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net patient service revenue</td>
<td>$570,312</td>
<td>$399,384</td>
</tr>
<tr>
<td>Other revenue</td>
<td>195,215</td>
<td>184,714</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td><strong>765,527</strong></td>
<td><strong>584,098</strong></td>
</tr>
</tbody>
</table>

### EXPENSES

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries, wages and employee benefits</td>
<td>337,823</td>
<td>312,449</td>
</tr>
<tr>
<td>Professional fees and purchased services</td>
<td>130,382</td>
<td>114,476</td>
</tr>
<tr>
<td>Supplies</td>
<td>93,681</td>
<td>83,386</td>
</tr>
<tr>
<td>Utilities</td>
<td>10,166</td>
<td>8,366</td>
</tr>
<tr>
<td>Other expenses</td>
<td>69,824</td>
<td>29,628</td>
</tr>
<tr>
<td><strong>Total Operating Expenses</strong></td>
<td><strong>641,876</strong></td>
<td><strong>548,305</strong></td>
</tr>
</tbody>
</table>

**Earnings before Interest, Depreciation and Amortization**

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>123,651</td>
<td>35,793</td>
</tr>
</tbody>
</table>

### DEPRECIATION, AMORTIZATION AND INTEREST

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depreciation and amortization</td>
<td>23,583</td>
<td>29,495</td>
</tr>
<tr>
<td>Interest</td>
<td>17,856</td>
<td>13,914</td>
</tr>
<tr>
<td><strong>Total Depreciation, Amortization and Interest</strong></td>
<td><strong>41,439</strong></td>
<td><strong>43,409</strong></td>
</tr>
</tbody>
</table>

**EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>$82,212</strong></td>
<td><strong>($7,616)</strong></td>
</tr>
</tbody>
</table>
statistical report

For the year ended June 30, 2011

**KEY STATISTICS**

<table>
<thead>
<tr>
<th>Metric</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of licensed beds</td>
<td>286</td>
</tr>
<tr>
<td>Discharges</td>
<td>11,470</td>
</tr>
<tr>
<td>Patient days</td>
<td>87,985</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>7.67</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>319,079</td>
</tr>
<tr>
<td>Emergency Room visits</td>
<td>62,415</td>
</tr>
<tr>
<td>Traumas treated</td>
<td>536</td>
</tr>
<tr>
<td>Medical transports</td>
<td>996</td>
</tr>
<tr>
<td>Surgeries</td>
<td>14,832</td>
</tr>
<tr>
<td>Active Medical Staff</td>
<td>528</td>
</tr>
<tr>
<td>Employees</td>
<td>4,966</td>
</tr>
<tr>
<td>Total National Institutes of Health funding</td>
<td>$26 million</td>
</tr>
<tr>
<td>Total research funding</td>
<td>$44 million</td>
</tr>
<tr>
<td>Total number of active patents</td>
<td>100</td>
</tr>
</tbody>
</table>

**CHARITY CARE AND OTHER COMMUNITY BENEFITS**

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charity care</td>
<td>$2.7 million</td>
</tr>
<tr>
<td>Unreimbursed costs of medical services for government-sponsored programs</td>
<td>$94.7 million</td>
</tr>
<tr>
<td>Research activities</td>
<td>$26.8 million</td>
</tr>
<tr>
<td>Health professions education</td>
<td>$26.0 million</td>
</tr>
<tr>
<td>Subsidized health services</td>
<td>$5.1 million</td>
</tr>
<tr>
<td>Community health improvement services and other community benefits</td>
<td>$5.8 million</td>
</tr>
</tbody>
</table>

**TOTAL COMMUNITY BENEFIT** $161.1 MILLION

---

1 Includes outpatient and lab visits.

2 Includes cost of care provided to those with no health insurance.

3 The Medi-Cal program partially offsets these losses through the Disproportionate Share Hospital Program, designed to support “safety net” hospitals, such as Children’s Hospital Los Angeles. The hospital received $44.7 million in Disproportionate Share Hospital funding in FY 2011.

4 In January 2010, the state of California enacted legislation that provides for supplemental payments to certain hospitals funded by a quality assurance fee paid by participating hospitals as well as matching federal funds (the “Hospital Fee Program”). The payments and fees under the Hospital Fee Program are retroactive to April 1, 2009. Supplemental payments and fees related to the Hospital Fee Program produced a net benefit of $114.4 million to Children’s Hospital Los Angeles in the fiscal year ended June 30, 2011.
Playrooms in each inpatient area are “ouch-free zones” for the children in our care. These rooms in the Anderson Pavilion are equipped with televisions, computers, games, art supplies and more to help kids continue to have fun while they get well. Here, 5-year-old Monica Valdivia and her mom, Elizabeth Lopez (center), play with Child Life Therapist Carola Mendez.

Spacious new patient rooms, 85 percent of which are private, offer natural light, playful ceiling decorations, plenty of room for patients, families and caregivers and the new GetWell- Network, an interactive resource of entertainment and educational options for children. At right, Sandy Salina, RN, helps Dana Avalos, age 9, navigate the network.

The Newborn and Infant Critical Care Unit consists of private and double rooms for all patients, and comfortable spaces for parents to be near their babies. The unit also increased in size from 34 to 58 beds. Here, Alba Vega bonds with her son, Sebastian Ochoa.

Family Lounges on every floor offer quiet space for families to relax, and also provide a place for staff to chat one-on-one with parents or offer training and education to families. At left, Jackie Gilberto, a health education services coordinator with the HOPE Program, counsels a parent.
Family alcoves located throughout the floors provide families with a nearby place to gather and relax outside of their child’s room.

While most rooms in the Anderson Pavilion are private, some are double patient rooms for those children on longer stays in the hospital who can benefit from interaction with other kids.

The waiting room in the new Maurice Marciano Family Foundation Emergency Department and Trauma Center features a sunken garden, bringing nature into the underground space.

Nurse stations in the Anderson Pavilion include adult-height counters as well as lower counters, so staff can see kids eye-to-eye.

The HBO Café is a popular spot in the Anderson Pavilion, with a wide variety of dining options for staff and families and outdoor seating in the Ralph M. Parsons Foundation Dining Terrace. The Terrace overlooks the Simms/Mann Family Foundation Playground in the Jane Vruwink Palmer Healing and Play Garden.

Patients, families and staff have settled into the Marion and John E. Anderson Pavilion after the big move on July 17, 2011. Take a look at our new home in action!
Imagine surviving a large-scale disaster, but becoming separated from your child. Months later, your child is still missing. You don’t even know if he or she is alive.

That’s what happened to thousands of people in the aftermath of Hurricane Katrina in 2005. More than 5,000 children were separated from their parents during the chaos that followed the Category 5 hurricane. Many children were even evacuated to different states than their families. It took six months for the last missing child—a 4-year-old girl—to be reunited with her parents.

Making sure that this nightmarish scenario doesn’t repeat itself in future disasters is one of the goals of the Pediatric Disaster Resource and Training Center at Children’s Hospital Los Angeles. Created more than a decade ago, the Center works to ensure that health care providers across Los Angeles County are prepared to care for children if disaster strikes.

Children’s Hospital itself will play a pivotal role in any disaster response in Los Angeles, as it operates the county’s only freestanding Level I Pediatric Trauma Center approved by the Los Angeles County Department of Health Services and accredited by the Committee on Trauma of the American College of Surgeons.
Preparing for Children

Henri R. Ford, MD, has seen firsthand what happens when a disaster strikes an area that is unprepared.

Ford, vice president and surgeon-in-chief at Children’s Hospital, spent two weeks treating children in Haiti after the Jan. 12, 2010, earthquake that killed an estimated 220,000 people and left the country in a shambles. Three teams of volunteer physicians and nurses from the hospital also traveled to the country to care for injured children.

“There was no infrastructure, no preparation at all,” says Ford, a native of Haiti. “Fifty percent of the population there is under 18, so the impact on children was extensive.”

Although the infrastructure in Los Angeles is far more developed than that of Haiti, pediatric disaster preparedness is still essential. In Los Angeles County, 29 percent of the population is under 18.

One of the Center’s newest initiatives aims to help solidify a more cohesive pediatric trauma network in California. In April, the Trauma Program sponsored a symposium for California health care providers who care for traumatically injured children, and it is preparing to send recommendations to state legislators. The goal: ensure that traumatically injured children receive the best care at the appropriate facility—during a disaster and every day.

Closer to home, the bulk of the Center’s work focuses on educating and training LA County health care providers in pediatric emergency treatment and supply needs, as well as family reunification planning.

“The Center also is serving as a state and national resource. In 2007, it expanded its activities after receiving a two-year, $5 million grant from the U.S. Department of Health and Human Services to improve community and hospital preparedness for public health emergencies.

Last year, Jeffrey S. Upperman, MD, director of Trauma and the Pediatric Disaster Resource and Training Center at Children’s Hospital, served on a subcommittee of the National Commission on Children and Disasters. Many of the recommendations in the commission’s 2010 report to Congress were based on the Center’s work.

“Just a few years ago, most disaster planning didn’t consider the needs of children at all,” explains Upperman, a trauma surgeon and associate professor of Surgery at the Keck School of Medicine of the University of Southern California (USC). “Now, because of our advocacy work, more people are starting to consider children not as a last thought, but as a first thought.”

That’s important because children are not miniature adults. Besides the logistical challenges that arise when kids become separated from their parents, critically injured children often require different treatments, equipment and drugs, and their bodies respond differently than those of adults.

“Just a few years ago, most disaster planning didn’t consider the needs of children at all. Now, because of our advocacy work, more people are starting to consider children not as a last thought, but as a first thought.”

– Jeffrey S. Upperman, MD
Are You Prepared?

No one likes to think about the possibility of a major earthquake or other disaster. But spending a little time to prepare can make a world of difference in keeping your kids safe.

Bridget Berg, MPH, administrative director of the Pediatric Disaster Resource and Training Center at Children’s Hospital Los Angeles, offers the following preparedness tips for parents:

• Talk to your kids. If your children are old enough to understand, talk with them about the plan for an emergency and how you will re-connect.

• Talk to your kids’ school or daycare provider. If an emergency occurs, what is the school or center’s plan for evacuation? For contacting you? For releasing your child to an adult?

• Plan for special needs. If your child is medication-dependent, make sure the school or daycare provider has a few days’ supply of that medicine.

• Make an emergency card. Your kids should have a card with emergency phone numbers. Include cell and landline numbers. Designate an out-of-state relative as an emergency check-in contact as well.

• Create an emergency supply kit. The most important component here is water—one gallon per person, per day, for three to five days.

“There really is no other organized, in-person training that focuses on children and disasters,” says Bridget Berg, MPH, the Center’s administrative director.

At Children’s Hospital, the Center organizes and evaluates disaster preparedness drills and hosts an annual Disaster Olympix, a fast-paced, hands-on experience that challenges individuals and teams in their response capabilities and critical thinking skills.

“The idea is to get people moving and thinking about critical issues in a fast-paced environment,” Berg notes. “Those are the skills they’ll need in a real disaster.”

Getting Connected

One of the major challenges of disaster preparedness in Los Angeles is the county’s vast, 4,000-square-mile sweep. To overcome the geographic barriers, the Center has turned to high-tech solutions and virtual linkages, including a fleet of InTouch Health RP-7® robots to help link specialists at Children’s Hospital to outlying facilities in a disaster. (See page 22 for more information on the RP-7 robots.)

The hospital’s new Marion and John E. Anderson Pavilion also is equipped with a Disaster Command Center, which will be mobilized in the event of an internal or external incident. The Center is complete with computers that can access the Los Angeles County Emergency Medical Services Agency, as well as HAM, satellite and multichannel radios.

The building’s Maurice Marciano Family Foundation Emergency Department and Trauma Center features a dedicated decontamination shower room, in the event that patients have been exposed to chemical, biological or neurological agents that could be transmitted to staff or other patients.

In addition, Children’s Hospital offers an array of online training resources, including a triage simulation video game called SurgeWorld and a Web-based user interface that helps hospitals estimate and plan for pediatric disaster care needs, including family reunification.

Whether virtual or face-to-face, disaster planning is ultimately about the human connection, Upperman adds. The most important element? Building strong communities.

“Disaster preparedness is not a once-in-a-lifetime function; it’s an everyday function,” he says. “It starts with communities working together and helping each other, every day of the year.”

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“Disaster preparedness is not a once-in-a-lifetime function; it’s an everyday function,” he says. “It starts with communities working together and helping each other, every day of the year.”
In both nursing and racing, you have to handle pressure,” notes Schrimpf, who joined the nursing staff at Children’s Hospital in 2008 after graduating from nursing school. “For me, they also share a similar adrenaline rush.”

An avid athlete, she became intrigued at age 13 with her younger brother’s BMX bike. “I thought it was cool,” she recalls. “I never thought it would go this far.”

She became a professional three years ago, after having won numerous state and national competitions over 11 years as an amateur. Schrimpf races for the Speedline/Supercross team (a BMX component manufacturer), which is co-sponsored by Fly Racing. She’s known for her fast sprints and her skill at “manualing,” or riding on her back tire to increase speed between jumps on the 1,200-foot track.

Only the top BMX racers earn enough money, usually from sponsorships, to make racing their sole career. Most women in the sport have second jobs.

Until this year, Schrimpf raced in one or two competitions per month all over the country. Her bikes and gear are sponsored, but she pays her traveling expenses. Now, she’s cutting back on racing, but she can’t imagine giving up riding altogether. She trains several times a week to keep her muscles in quick-fire condition—essential with a typical race only lasting about 30 seconds. Practicing sprints “is a great stress-buster after a 12-hour shift,” she says.

At Children’s Hospital, her patients include children with neurological, gastrointestinal and orthopaedic conditions. Occasionally, she’ll meet a child with a bike-related injury and can easily relate. While in nursing school and training for the Olympic trials, she tore a ligament in her knee. She’s also broken her hand and several ribs, and had numerous scrapes and bruises.

Her patients love to hear her racing stories—another instance when her two careers intersect. “I always use the opportunity,” she says, “to reinforce the importance of a wearing a helmet.”
Beginning in 2010, Johnny Hoffman was treated at Children’s Hospital Los Angeles for cerebellar ataxia. His mother, Christina, shared the family’s story at a reception for the First Families Legacy Program on June 7, 2011, celebrating the completion of the Marion and John E. Anderson Pavilion.

My husband Paul, my son Johnny and I are honored to be here tonight to share Johnny’s story. You and your families have contributed so generously to establish this new building. It is truly the chance of a lifetime for our family to be able to thank you in person for all that you do.

Our story starts one year ago. Johnny had just finished kindergarten, and apart from broken bones and skinned knees, our three children had been happy and healthy.

Things changed dramatically the morning of June 15. We woke up to find Johnny on the floor in his bedroom, scooting himself on his hands and knees. I asked John what he was doing. He said, “I need to go to the bathroom but I can’t walk.”

Over the next eight days, we received many diagnoses, including a condition that is similar to polio.

His condition worsened. John was in and out of lucidity, he could not stand without assistance, he was throwing up, his speech was severely slurred and no one really had definitive answers to our desperate questions.

At the encouragement of our dear friends Kristin and Jeff Worthe, who are here tonight, we transferred Johnny to Children’s Hospital Los Angeles. We will always be grateful to you, Kristin and Jeff, for helping us at one of the most difficult times of our life. Kristin and Jeff have been dedicated to Children’s Hospital since their daughter, Lou Lou, had a life-saving heart surgery.

When we arrived at Children’s Hospital, we did not know if Johnny would ever walk again. We had no plan and were in a dark place. Then the lights came on.

Dr. Tena Rosser, a neurologist, and her team quickly diagnosed Johnny with acute cerebellar ataxia, caused by post-infectious cerebellitis. What this means was that John’s immune system had attacked a bacterial or viral infection, but instead of stopping, it continued attacking his brain.

As I was told, having cerebellar ataxia is like drinking a fifth of tequila. Alcohol affects the cerebellum. Thus, Johnny completely lost his balance, his coordination, his judgment, his short-term memory and his ability to speak clearly.

We asked difficult questions and the doctors always gave honest answers, with sensitivity and compassion. It was empowering to have a solid diagnosis that comes from years of experience seeing hundreds of thousands of children with disorders that manifest themselves in unique ways. Dr. Rosser and later Dr. Wendy Mitchell, another brilliant neurologist with a swath of bright pink hair, are not only top in their specialty, they are excellent communicators and just very human.

The treatment for cerebellitis is time and therapy, lots of it. John was then assigned to the Rehabilitation Unit and treated by the amazing and energetic Dr. Kevan Craig. The doctors, nurses and therapists on Six North are beyond competent and skilled—they are patient, full of encouragement and very positive. A team of angels—each and every one of them.

By Christina Hoffman
Six North is a tough floor; about half the kids have undergone brain surgery due to cancer or autoimmune disease. There are cerebral palsy patients, some trauma victims and then patients with a host of mysterious neurological diseases. We quickly realized that Johnny’s condition and our challenges were the least severe on the floor. It was humbling.

Johnny and the other children on Six North receive six hours a day, six days a week of physical, occupational and speech therapies.

Like many kids, at first he was overwhelmed with his own disability and the severity of the illnesses of those around him. At night, he was zipped up in a tent bed because he was a fall hazard. “Camp Rehab.” Gradually he came out of his shell and got to know the other Six North kids. We began to eat meals with the other families in the Six North common area. John’s face started to show joy when he beat a therapist at Uno, or high-fived his friend when they made baskets in the pop-a-shot from their wheelchairs.

There is a sign above the Six North community area that says, “A positive attitude is a powerful force.” That statement says it all, the mantra of Six North. It was never “What can’t we do,” but always, “What can we do today.”

It was a privilege to meet the patients and their families—all so brave, all so grateful their kids were being treated where they were.

Dr. Craig held a family team meeting about a week after John arrived. All of the team members on John’s case—doctors and therapists, even a staff psychiatrist—discussed the diagnosis and a plan for the future.

This synergy of talent is unlike any health care experience we are aware of anywhere.

As the days passed into weeks, again, in a sensitive and thoughtful manner, we were told it would be best for John to move to a school in the fall with a special education program, as he would have special needs for the next one to two years, or more. This is an example of the family-centered care you have heard so much about.

One of the discharge tests for the kids who are medically stable is a walk one block north to the Thrifty for an ice cream cone. I wish you could have seen our group—each child struggling so hard to walk one city block. Rainbow sherbet and cotton candy ice cream never tasted so delicious.

As we approached discharge, we knew that John would continue outpatient therapy at Children’s Hospital no matter what. His outpatient therapy, each Monday, was every bit as excellent as his inpatient program. Now, when we see John shoot a basket, or swim a lap, or ace a spelling test, we are grateful to Children’s Hospital Los Angeles.

Because of the care and compassion we received from the miracle workers here, we vowed to become involved at Children’s Hospital. To me, it is a sacred place. An example of the depth of the impact it’s had on Johnny was when, back in December, he asked me if he could come to the hospital to visit patients on Christmas. Thanks to Bonnie McClure, who is also here tonight, we were able to help wrap and deliver presents on Christmas Eve.

On April 30, John did not walk the Turn on the Lights! 5K, he ran it—with enthusiasm, with passion and with his own two feet.

You who are here tonight share that passion. With heartfelt gratitude and on behalf of thousands of families, thank you for making the world a better place.

“The doctors, nurses and therapists on Six North are beyond competent and skilled—they are patient, full of encouragement and very positive. A team of angels—each and every one of them.”

– Christina Hoffman
high-tech helping hands

With an assist from a special robot, surgeons at Children’s Hospital Los Angeles can perform complex surgeries with far less pain and scarring.

Someday, Murphy Glynn will tell his friends the story of how a giant robot delicately reached three massive steel arms deep into his belly while he slept. The hulking arms then twisted and turned and poked and prodded until they had fixed his insides. From that day on, he didn’t get sick anymore, and he never had to spend another night in the hospital.

Of course, his friends probably won’t believe him—especially since he won’t have the scars to prove it. But there’s nothing imaginary about his story.

In fact, over the past three years, surgeons in the Pediatric Robotic Surgery Program at Children’s Hospital Los Angeles have performed more than 200 robot-assisted surgeries on kids like Murphy. The program is the only one of its kind for children in California, and it’s the largest such program in the southwestern U.S.

“This isn’t science fiction, and it’s not experimental,” explains Chester J. Koh, MD, FACS, FAAP, director of the hospital’s Pediatric Robotic Surgery Program. “At Children’s Hospital, robotic surgery has become routine for certain procedures. It’s changing the standard of care.”

The program began in 2008, when a gift from the Joseph B. Gould Foundation enabled the hospital to purchase a $2 million da Vinci® Surgical System. Created by Intuitive Surgical Inc., the robotic system allows surgeons to perform complex reconstructive surgeries in a minimally invasive way, using tiny incisions the size of a pencil eraser.

For kids, those tiny incisions translate into less pain, minimal scarring, faster recovery times and less time in the hospital—typically only one night. Success rates are equivalent to those of open surgery.
That was music to the ears of Murphy’s parents, Megan and Matt Glynn. At birth, one of Murphy’s two ureters—narrow tubes that drain urine from each kidney—was improperly connected to his bladder. As a result, urine would sometimes flow backward (reflux) into his kidney.

Murphy had been hospitalized multiple times with kidney infections. To permanently fix the problem, he needed reconstructive surgery. Three pediatricians all referred the Glynns to Koh.

“We didn’t know robotics was an option until Dr. Koh explained it,” Megan says. “As soon as we heard about it, we knew it was the only option.”

On a warm Thursday morning in July, the 2-year-old went in for his surgery at Children’s Hospital. Instead of being at the operating table, Koh performed the bulk of the surgery while seated at a space-age-looking console in the corner of the room. At the table, the robot’s three arms were inserted through the belly’s tiny incisions. One arm contained a high-resolution camera with two lenses, while the other two arms contained surgical instruments.

Looking down through two eyeholes at the console, Koh had a 3-D view of Murphy’s bladder and ureter and the two surgical instruments, magnified to 10 times their actual size. The specialized instruments have a jointed-wrist design at the tip that exceeds the human hand’s natural range of motion. The result is unmatched precision.

Grasping the console’s two dangling joysticks, one in each hand, he expertly maneuvered each instrument to create a longer “tunnel” in the bladder wall and reposition Murphy’s ureter inside it to prevent reflux.

“The surgery is always performed by the surgeon,” stresses Koh, assistant professor of Pediatric Urology at the Keck School of Medicine of the University of Southern California (USC). “The robot can’t make a single move without a surgeon guiding its arms.”

The robot is just one part of Children’s Hospital’s commitment to providing minimally invasive surgical options, says Henri R. Ford, MD, vice president and surgeon-in-chief at Children’s Hospital. “We feel it’s our responsibility to pioneer and champion new technologies that allow us to deliver the best surgical care with the least pain and scarring,” explains Ford, vice dean of Medical Education and professor and vice chair for Clinical Affairs, Department of Surgery, at the Keck School of Medicine of USC.

Murphy’s surgery went off without a hitch. It was a huge relief for his parents, especially since Matt, who serves in the Air Force, was deploying to Afghanistan the following month.

Murphy went home the morning after his surgery. “By that night, he was bouncing off the sofa, with no pain medication or anything,” his mom says. “The whole experience was so easy for him.”

And he’s going to have a really cool robot story to tell his friends.

“This isn’t science fiction, and it’s not experimental. At Children’s Hospital, robotic surgery has become routine for certain procedures. It’s changing the standard of care.”

– Chester J. Koh, MD
Five-year-old Justin DeLong had no signs of illness. He was just unusually pale for a couple of weeks prior to his regular annual checkup. But his coloring immediately concerned Justin’s pediatrician, who ordered a series of blood tests that showed an alarmingly high white blood cell count.

Within 24 hours, the DeLong family’s lives were changed forever. Following a bone marrow aspiration test at an adult oncology office near the family’s Santa Clarita home, Justin was diagnosed with acute lymphoblastic leukemia (ALL).

“Early on, we knew the prognosis was poor,” says Lisa DeLong. “But Justin was such a happy child. He always had that smile, and now we’re not as happy.”

Within months, Justin began chemotherapy. But the cancer wasn’t going away. By his 10th birthday, doctors recommended a bone marrow transplant. Justin was given a 20% chance of survival.

But Justin’s battle didn’t end there. In eighth grade, he and his two younger sisters, Jessica and Joelle, all caught the flu. While his sisters quickly recovered, the low-grade fever and body aches lingered for Justin. The lymph nodes along his jaw line became swollen, alerting his physicians to perform a blood test. Their worst suspicion was true—the leukemia was back. Justin began aggressive chemotherapy, but five months into his treatment, he died, just 12 days after his 15th birthday.

For the DeLongs, the first few weeks following diagnosis were “surreal,” but soon there was hope. Justin was responding to the chemotherapy. While he missed his entire kindergarten school year, he slowly returned to normal activity as he underwent treatment until he was 8. By his 13th birthday, he was considered “clinically cured,” with five years in remission, and was growing into an athletic young man who competed in long-distance races and played football in his school’s Turkey Bowl.

Physicians and researchers have been baffled by why the cancer in some children continues to quietly grow, despite the most advanced drugs. But now, they have some answers.
ALL, a cancer of the white blood cells, is the most common form of childhood cancer. While most children survive, about 15 to 20 percent of patients, like Justin, do not respond to treatment, according to Stuart Siegel, MD, director of the Children’s Center for Cancer and Blood Diseases and head of the Division of Hematology-Oncology. Physicians and researchers have been baffled by why the cancer in some children continues to quietly grow, despite the most advanced drugs. But now, they have some answers.

This group of patients has been the focus of intense research currently being conducted at Children’s Hospital Los Angeles. A team of scientists led by Markus Müschen, MD, an investigator at The Saban Research Institute of Children’s Hospital Los Angeles, has identified a reason for drug resistance in some patients—BCL6, a protein that some leukemia cells use to stay alive and avoid the lethal effects of chemotherapy.

“This protein allows the cancer cells to enter a state of dormancy, helping them to survive when the patient is treated with chemotherapy,” says Müschen, professor of Pediatrics, Biochemistry and Molecular Biology at the Keck School of Medicine of the University of Southern California (USC). “After treatment is complete, in some cases, these sleeping cancer cells can wake up and the disease recurs.”

Müschen and his team of investigators at Children’s Hospital and eight other medical research facilities have been able to eradicate sleeping cancer cells that would otherwise survive dormant in animal studies. Their study shows that an investigational drug, RI-BPI, developed at the Weill Cornell College of Medicine, used in combination with the conventional cancer drug, Gleevec, shut down dormant cancer cells that give rise to leukemia. The study was published in the May 2011 issue of Nature, the nation’s most highly cited interdisciplinary science journal.

Müschen and his team began their research four years ago to unravel the puzzle of how some cancer cells enter a “sleeping mode” to weather even aggressive and powerful drugs used in conventional chemotherapy. They discovered that the BCL6 protein increased dramatically following treatment.

The protein’s job—to allow the cancer cells to survive in dormancy. While not every leukemia patient has this particular protein, for those who do, targeted therapy to disarm it could mean a chance at preventing the disease from striking again.

“This is a novel approach to treatment for leukemia because we are learning how and why resistance forms and focusing our attention on developing very specific agents,” says Siegel, professor and vice chair of Pediatrics at the Keck School of Medicine of USC.

As Lisa DeLong explains in her recent book, “Blood Brothers,” chronicling her family’s journey, the relapsed leukemia was waging a battle within Justin’s bone marrow. Healthy cells found themselves in combat with defective white cells multiplying so quickly that organ failure became imminent.

But for the DeLongs, Müschen’s study has even bigger ramifications. Not only did they lose their oldest son to ALL, but their youngest son, Jacob, was diagnosed with the same cancer at age 6. The 11-year-old was successfully treated at Children’s Hospital, where for more than five decades, physicians have been leading innovative clinical and research programs. While Jacob is now in remission, the possibility of a relapse is an unfortunate fear that the DeLong family must live with every day.

Lisa poignantly captures the urgency of treatment and the emotional strain following Justin’s relapse in her book: “One moment you are planning mashed potatoes and gravy for dinner, and then, with one ring of the phone, you’re planning trips to the oncology ward … The uncertainty of surviving was insufferable. I loathed having to battle this beast again.”

Müschen recently was awarded a $3.6 million grant from the California Institute for Regenerative Medicine to move the results of his research into clinical trials. His goal is to optimize the new treatment regimen and obtain approval from the FDA for use in patient care. It’s the courage of children like Justin and Jacob and the unbreakable spirit of the families who support them throughout the chemotherapy, radiation, blood transfusion, hair loss, nausea and long stays in the hospital that inspire Müschen and his colleagues’ research.
A neonatal intensive care unit (NICU) is filled with sophisticated electronics that enable doctors and nurses to monitor their young patients or intervene at a moment’s notice. Amidst the intricate monitors, pumps, flashing lights, tubes, dials and buzzers, a helpful robot fits right in.

That’s the conclusion of a research study conducted by a team of neonatologists at Children’s Hospital Los Angeles, who tested and demonstrated the safety of using a remote-controlled robotic telemedicine system in the NICU at Hollywood Presbyterian Medical Center. The robot was directed by a physician located at Children’s Hospital.

Their investigation, recently published in the *Journal of Perinatology*, was driven by a real-world problem facing fragile NICU babies—a shortage of available experts to treat them.

Over the past few decades, the demand for NICUs has risen, driven by an increase in preterm and multiple births and advances in neonatal medicine. “However, many community hospitals don’t have the luxury of 24-hour staffing by neonatology specialists,” notes Arlene Garingo, MD, a physician in the Children’s Hospital Center for Fetal and Neonatal Medicine and lead author of the study.

Currently, when an emergency occurs in a lower-level NICU (Levels I and II), an off-site neonatologist typically must immediately assess the patient without seeing him or her, based on information provided via telephone by nursing or respiratory staff. By contrast, the Children’s Hospital Newborn and Infant Critical Care Unit (NICCU) is Level III—the highest possible ranking, with 24/7 neonatal-perinatal subspecialist staffing.
“Telemedicine offers the ability to provide the expertise of specialists and subspecialists at places where their physical presence is not possible. It shows tremendous potential for improving health care delivery and outcomes,” says Philippe Friedlich, MD, MSEpi, MBA, medical director of the NICCU at Children’s Hospital.

Telemedicine has been used in limited ways in the neonatal setting for consultation or sharing of images. The trailblazing Children’s Hospital study marked the first time a robot was employed as a virtual “stand-in,” with the actual physician off-site controlling the robot. The results were encouraging, but Istvan Seri, MD, PhD, HonD, director of the Center for Fetal and Neonatal Medicine, voices caution.

“This study is just the first in a series of studies that must be performed before we can recommend remote-controlled robotic telemedicine for routine use in community hospitals, with or without a link to a children’s hospital or large medical center,” says Seri, professor of Pediatrics at the Keck School of Medicine of the University of Southern California (USC).

To test their theories, the researchers used remote control stations in their offices at Children’s Hospital, complete with a computer, joystick, speakers and headsets. They then installed the robot—known officially as the “RP-7 Presence System” from InTouch Health—at Hollywood Presbyterian Medical Center, site of one of the NICUs in the Neonatal Academic Network under operation by the Center for Fetal and Neonatal Medicine. Hollywood Presbyterian Medical Center is located next door to Children’s Hospital Los Angeles.

That’s where Rajeshh Raghavan and Priya Narayanan Unni met the robot this past June, after their daughter, Thea Aileen, was born four weeks premature. She weighed only 3 pounds, 9 ounces.

Raghavan expected the robot to resemble its movie counterparts, with legs, arms and a nuts-and-bolts face. “But this robot is quite different,” says the new dad.

What RP-7 does have matters more—namely, two-way, real-time audio and video communications capabilities, including a video camera that can pan, tilt or zoom, microphone and a digital stethoscope. The robot has a motorized platform that is controlled by the off-site physician and allows it to be maneuvered in the NICU.

When not in use, RP-7 resembles any other NICU machine. “When the screen lights up with the off-site neonatologist’s face, it takes on human characteristics,” says Friedlich, associate professor of Clinical Pediatrics at the Keck School of Medicine of USC.

Raghavan, a database administrator at a Los Angeles-based film studio, is accustomed to technological advances. “Medical science has to move forward,” he says. “This study is helping the doctors know more about the robotic system and how to optimize it.”

Using the screen, the off-site neonatologist could see Thea Aileen and her parents and talk directly to the couple. “We felt our daughter was well cared for,” says Unni. Thea Aileen went home after 20 days in the NICU and is thriving.

During the study’s first phase, the robot helped treat 46 premature and full-term newborns, in a total of 304 patient encounters. Each infant was evaluated by two neonatologists—one in the Hollywood Presbyterian Medical Center NICU and one off-site, at Children’s Hospital.

Among other things, the research team examined whether the robot could be safely maneuvered around the NICU, as well as whether the neonatologist at the controls could read the medical charts and monitors and fully observe the patient. The answer, on all counts, was a resounding yes.
Telemedicine offers the ability to provide the expertise of specialists and subspecialists at places where their physical presence is not possible. It shows tremendous potential for improving health care delivery and outcomes.

– Philippe Friedlich, MD

The team also compared patient assessments by the on-site and off-site physicians. Agreement generally ranged from good to excellent. Certain aspects of the physical exam showed differences in agreement, such as assessing breath, heart and bowel sounds. This led the researchers to do a study within the study. They found that such assessments are subjective, and the rate of agreements between two on-site physicians was similar to agreements between the on-site and off-site neonatologists.

The work was primarily supported by grants from the UniHealth Foundation. Additional support was provided by The Laura P. and Leland K. Whittier Virtual PICU Junior Faculty Fellowship for Research in Telemedicine Program.

In an ongoing study also supported by funding from the UniHealth Foundation, the researchers are studying the efficacy and cost-effectiveness of using remote-controlled telemedicine to treat neonates.

Acceptance of the use of the remote-controlled robotic telemedicine system by parents and staff is extremely important as well. However, it doesn’t seem to be an issue. “Many parents who grew up with technology see the robot as simply a new way to communicate with their physician,” says Garingo, assistant professor of Pediatrics at the Keck School of Medicine.

“Indeed, after a little time, nurses and parents started talking to the robot as if it was me,” Seri says. A few parents even hugged RP-7. One mother asked to pose for a picture with her baby and the robot—something special to show her daughter when she grows up.
a little girl, a lot to teach

There are many reasons why 7-year-old Regan Owens shouldn’t be alive. Her family is thankful that she is—and grateful for Children’s Hospital Los Angeles.

When she was born, doctors gave Regan Owens a few weeks to live.

Seven years later, the spunky first-grader is always the life of the party, and never without a Justin Bieber song to sing.

“You should watch the movie about him,” Regan says, as one of the teen heartthrob’s tunes plays from her mother’s iPad. “It will change your life.”

Her mother, Natalie Owens, smiles and shakes her head as her daughter bops from side to side. Regan knows all the words to all of his songs.
Despite the Odds
Regan was born in 2004 with multiple health issues and was diagnosed with Fanconi anemia. She had an interrupted esophagus, a hole in her heart, fused horseshoe-shaped kidneys, a connection between her esophagus and her lungs and no thumbs—all complications related to the rare genetic disorder.

Surgeons at Children’s Hospital tackled the most severe health issues first. They fixed the interruption in her esophagus and disconnected it from her lungs so that Regan could be fed, and they mended her heart.

One by one, Regan made it through the surgeries, while she and her family got to know staff in at least seven different departments at the hospital. Along the way, she also faced long hospitalizations for leukemia, recurring bouts of pneumonia and surgery for her hip.

Without blood transfusions, most of the procedures surgeons performed to save Regan’s life would not have been possible. Her family and friends, with the help of the hospital’s Blood Donor Center, now hold a drive each year to support the center.

Rare blood types within certain ethnic populations, especially blacks and Hispanics, make it crucial for people of these ethnicities to donate, says Aileen Jenkins, supervisor of the Blood Donor Center at Children’s Hospital Los Angeles. Such donations are particularly important for patients with sickle cell disease and thalassemia.

“One of our patients need five units of blood a month,” Jenkins says. “That’s a lot of exposure to people who are not like you. And the more you’re exposed, the more potential there is to form proteins that can reject blood.”

Considering that there are many more blood types than are generally known, it’s important to find donors who closely match patients, she explains. Patients at Children’s Hospital need 200 to 300 units of specially matched blood a month.

That news came as a shock to Regan’s aunt, Jacqueline Owens-Fleming.

“I didn’t know that it’s more effective for someone to receive blood from the same race,” Owens-Fleming says. “That blew my mind, and it changed my conversation. Now I tell people every chance I get.”

Life-Changing
For all of the family, watching Regan recover from each surgery and illness has been hard but inspiring.

Through Regan’s adversities, they’ve all learned to appreciate life and each other more. If anything, the already tight-knit family grew stronger, Natalie says.

Regan’s 10-year-old brother donated bone marrow to his sister when she was treated for cancer. He and his brothers and sisters all help to take care of her, too.

“She’s taught all of us to keep moving and not to complain about the little things so much,” Regan’s mother says.

Owens-Fleming agrees. After Regan was born, she began to think more about the way she lives.

“I wasn’t the healthiest,” she says. “Regan helped me make more of an effort to exercise and eat better.”

Along with the blood drives, the family also has become more involved with efforts to support Regan and the hospital. This past spring, 25 relatives and friends formed the “Regan’s Joy” team and participated in the Turn on the Lights! Walk for Kids.

Though they had planned to walk, too, Natalie was with Regan in the hospital for the hip surgery.

“There are so many things you can do, like donating blood, that don’t cost anything except your time,” Owens-Fleming says. “And it’s such a wonderful gift.”

—I didn’t know that it’s more effective for someone to receive blood from the same race. That blew my mind, and it changed my conversation. Now I tell people every chance I get.”

— Regan’s aunt, Jacqueline Owens-Fleming
A Better Family
There aren’t many things that leave Regan speechless. The idea of meeting Justin Bieber does.

“Don’t even get me started,” she says, between singing his songs. “Baby, baby, baby, oooh … Mommy, we have to go to a concert.”

Nurses pop in and out of the exam room to dance while the pair wait. Natalie laughs, and assures Regan that she’ll see her favorite singer perform live one day. It wouldn’t be the first famous star she’s seen in person.

Through Children’s Hospital, Regan showcased her singing talents on an episode of “Glee” with other patients, where they met the cast and crew. She also got to sit on Heidi Klum’s lap when the model and television show host dropped by for a visit.

“She misses a lot, and the experiences we’ve had here have given her something extra, something that’s her own,” Natalie says. “The doctors and nurses are over the top, and from Juanito in valet parking to the lady who cleaned our room during the last stay who read to Regan in Spanish to teach her, everyone in this place is amazing.

“The hospital is our second home,” she says. “I always say that I hate this place, but I love it. We hate why we have to go but love the people.”

As much as her heart aches, being a mother with a sick child, she says she wouldn’t change anything for the people and the experiences.

“It’s made our family better.”

The MaxMobile—Coming to a Location Near You

Blood donations impact many patients at Children’s Hospital Los Angeles. Transfusions help patients to recover from surgery, provide essential red cells and platelets for those with cancer and help others deal with life-threatening blood disorders. They also are vital in emergencies.

More than half of the blood collected by the hospital is donated to Children’s Hospital by virtue of blood drives organized throughout the community. These community drives are made possible with the help of the “MaxMobile”—the hospital’s bloodmobile.

At 40 feet long and 12 feet wide, the MaxMobile can accommodate up to 100 donors at a single blood drive.

Named after patient Max Beulow, the vehicle is designed to be a comfortable and safe way to donate blood outside the hospital. After Max died of cancer, his family and friends raised most of the money needed for the vehicle, with support from the hospital as well.

The Los Angeles Kings Blood Mobile, a supply vehicle that accompanies the MaxMobile or travels to blood drives on its own, also is a vital component of the hospital’s Blood Donor Program.

These two vehicles travel throughout Los Angeles County and occasionally can even be seen in Ventura and Orange counties. They can come to you, too!

If you’re interested in holding a blood drive, please contact the Children’s Hospital Los Angeles Blood Donor Center at 323-361-2441 for more information.
Experienced pediatric nurses at Children’s Hospital Los Angeles have created a dynamic education forum for parents called “RN Remedies,” a weekly feature on the hospital’s WeAreChildrens.org blog. Questions similar to those posed by parents at the hospital are posted online and answered by trusted pediatric health professionals.

Since the feature’s inception in November 2010, a core group of eight nurses have posted on a wide range of topics, including discussions of common childhood conditions, safety tips for injury prevention and teen health. Featured here are two popular posts from the series. To read more, visit WeAreChildrens.org.

Breaking Down Broken Arms
by Gloria Verret, RN, CPN
RN III at Children’s Hospital Los Angeles

There we were, four families gathered for one of our nightly dinner parties during our annual stay at a mountain cabin when we heard a THUMP and the tell-tale sound of injury: a child beginning to cry.

Until that moment, the children had been running around the big mountain cabin as they played. Then, one of the boys had taken a tumble off the porch steps. As the adults arrived on the scene, a 9-year-old was crying and holding his left arm. Knowing that I work at Children’s Hospital Los Angeles in the Department of Rehabilitative Medicine, all the adults then looked to me for next steps.

“OK, orthopaedic nurse,” they said, “Is it broken?”

I went over to assess my new “patient.” When I looked at the arm, I could not see anything very remarkable about it. There was no bone protruding (thank goodness!) and no bleeding. I couldn’t see any deformity, either. But as I looked at this young man’s face, I saw that it was pale and sweaty, and he was trying hard not to cry. I asked him to tell me his pain level on a scale of 1 to 10 (1 being no pain and 10 being the worst pain he had ever felt).

Quietly, he answered, “10.”

His parents looked at me and asked, “It’s not broken, is it? The nearest emergency room is two hours away down the mountain.” I explained to his parents that I believed it might be broken, not because I could “see” the fracture, but because I could see the boy’s physical response to the incident. Down the mountain the family went, and called us hours later. His arm was indeed fractured.

Kids are resilient, dusting themselves off, one spill after another. But one wrong move often can result in a broken bone. A broken arm is almost a cliché symbol of “rough and tumble” boyhood. It seems to occur so frequently among rambunctious youngsters that some parents might think the injury is “not a big deal.” However, a broken arm is definitely no laughing matter and requires immediate medical attention.
Facts about Broken Arms

- Ratio of Boys to Girls: Fractured arms are two times more common in boys than girls.
- Age: Fractured arms are most common in children ages 5 to 9, as the joints are looser at this age.
- Open Fractures: Open fractures (injuries in which a broken bone is open through the skin) are rare. Mostly they occur from a direct fall onto an outstretched hand.
- Fracture Symptoms: Symptoms include pain, swelling and deformity at the elbow joint.

Diagnosis of Fractures
Fractures require an X-ray to determine the type of fracture. Despite comments from friends that, as an orthopaedic nurse I should have “X-ray eyes,” the only way you can ensure that a child does not have a fracture is by visiting a radiology lab. Emergency rooms and hospitals have access to radiology lab settings 24 hours a day. Based on the type of fracture identified, the doctor will determine the best course of treatment.

Better Safe Than Sorry
During the years I worked as an orthopaedic nurse, I saw children whose parents refused to believe medical attention was needed. In some cases, these parents even visited a massage therapist for what they felt was a minor wound. However, these children usually still ended up at a hospital because their pain would not subside as the injured limb became swollen and more deformed-looking.

Risks of Delaying Fracture Treatment
The risk of not treating fractures is that important nerves and blood vessels that are near the elbow joint can be injured. Without correcting the displaced bones, the nerves and vessels could be permanently damaged. Another risk is malunion, which takes place when the bones are not aligned correctly. This can result in the patient losing complete movement or experiencing deformity. A greater threat is compartment syndrome—the compression of blood vessels, nerves and muscle inside a closed space or “compartment” within the body. It is very painful and can result in serious injury and in extreme cases, amputation or death.

Parents know that if they suspect their child’s bone has been broken to take them to the hospital. Waiting too long to treat a fracture could result in complications that could easily be avoided. At Children’s Hospital Los Angeles, our Emergency Department and our Children’s Orthopaedic Center are specifically equipped to treat broken bones in children. Although these often are quick fixes, they are vital for the health and future of the injured child!
Adventure Equals Allergy
My 7-year-old, Jojo, self-diagnosed a few years ago, declaring himself allergic to fruits, vegetables and almost anything green, except for Kermit. (No, he does not eat frogs.)

So you can imagine my delight when he picked up some pistachios left over by grandma one Friday and asked me, “Are these good for you?”

My enthusiastic answer was, “Absolutely!”

I was intrigued to watch him finish the entire bag of nuts, after his careful examination of their light green flesh.

Prior to this experience, Jojo would always make sure to check his plate for any speck of green, which he would meticulously move to the side of his plate with his fork.

The two bags of pistachios I brought home from the local market the following day did not last long in our house. This kicked off days of adventure for Jojo’s palate. He was trying tons of new foods until he happened to try some ginger snaps and cinnamon rolls from a nearby bakery. On Wednesday evening I noticed pinpoint rashes and some hives covering his chest and back! I checked him from head to toe, looking for any swelling on his face, particularly around his eyes, lips, tongue and neck. Putting on my nurse cap, I asked a few questions:

“Are you itchy?”
“No.”

“Have you been scratching?”
“No.”

Despite his answers, it still looked to me like my son was experiencing an allergic reaction. I gave him over-the-counter chewable antihistamine I had on hand, following the directions on the container, and put him to bed. He slept soundly that night.

By the morning his hives were gone, but the rash was still there. I called Jojo’s pediatrician, who could only give me an afternoon appointment.

I was given the choice to come in early and wait to be seen, but I knew I could end up waiting hours without an appointment, so off to school he went, sadly with a much leaner lunch box than normal. I didn’t want to take any chances.

How Do I Know if My Child is Having an Allergic Reaction?
Finding a rash on a family member can be alarming. Without knowing what is causing the rash, parents often immediately wonder whether their child’s rash is contagious before they think of allergies as the cause.

In Jojo’s case, it was easy to suspect he was experiencing an allergic reaction because we distinctly remembered new items introduced into his diet just before he broke out in a rash.

In addition, no one else in the family had the same rash, which led me to believe it wasn’t contagious. However, we continued to watch each other to rule out this possibility.
Checking for Allergies
Here are some immediate steps you can take when you suspect allergies:

1. Check for any difficulty in breathing.
2. If the child starts feeling a lump in the throat, any shortness of breath or wheezing, CALL 911.
3. Watch for other symptoms, which can include:
   - Runny or stuffy nose
   - Sneezing
   - Itchy, watery eyes
   - Facial swelling, around the eyes and lips
   - Swelling of the tongue and throat
4. Recall and list any new food, hair and skin care products (shampoo, conditioner, lotions or cream). Don’t forget to include soaps (bath or detergent).
5. Recall and list any changes in products or foods you usually encounter in your home or environment. (In Jojo’s case, we had recently purchased products with ginger and cinnamon from a bakery that was new to us.)

Oral Antihistamines
Oral antihistamines such as diphenhydramine (Benadryl) can be given to ease mild symptoms of allergies. However, they can often cause drowsiness and inability to concentrate in school. Non-drowsy antihistamines that provide temporary relief are available, such as loratadine (Claritin) and cetirizine (Zyrtec).

Upon determining foods and products to which a child is allergic, it’s important to keep a list of things to avoid.

Keeping an Allergy Diary
I prepared for my son’s appointment with his pediatrician by writing out a diary of the previous days, listing any new foods my son had eaten during that time, as well as what he didn’t eat and my observations during that time.

It helped me to present my son’s pediatrician with the most accurate picture of the days prior to the rash.

Here’s how it ended up looking:

**Wednesday**
- 8 p.m.: Mild itching, noted hives and pinpoint rash on back, chest and abdomen, no respiratory difficulty
- NO swelling of the face, eyelids, lips, tongue, throat, runny nose
- Benadryl 18 mg given
- 10 p.m.: slept, no issues

**Thursday**
- 8 a.m.: Mild itching, hives disappeared, increased rash on trunk, chest, abdomen, neck behind ears, forehead. Rash redder.
- NO swelling of the face, eyelids, lips, tongue, throat, runny nose
- No medicine given, went to school
- No other family member with same symptoms

Recent History: Significant only for eating pistachios since Friday (this is new), ginger snap cookies from Swedish bakery since Monday (has had food with ginger as part of ingredients) and cinnamon buns from Swedish bakery (has had cinnamon before).

No new skin and hair products.

This diary was a very useful tool to help me figure out which foods specifically caused my son’s rash. While I have the benefit of education and training as a nurse to help guide me, parents also can use a diary when trying to narrow down which foods might be causing their child to have an allergic reaction.

Coming prepared to a doctor’s appointment with this information will help your child’s pediatrician during the diagnosis process.

A Pause from Pistachios … and Other Things
The pediatrician told Jojo that for at least two weeks, he was not allowed to eat the three things he had most recently added to his diet:
1. Pistachios
2. Ginger snaps
3. Cinnamon rolls

Jojo also had to take oral steroids for four days and was prescribed hydrocortisone to rub onto the areas of his skin where he experienced severe itching.

Additionally, I sent his teacher a note about the incident. I made sure to inform her about what food items caused the allergy, so that she would be aware in case they were included in any school snacks or treats brought to class from home by other students.

Sharing Your Child’s Allergy Information
It’s very important to make sure that a complete listing of your child’s food allergies is shared with as many people as possible. Sharing this information with all the members of the household, the teacher and friends or relatives who might feed your child will help minimize risk of exposure to the foods in question.

There is no definitive list of safe foods, as allergies can be as unique as individuals. However, below are some useful resources for parents hoping to find foods that are free of the item to which their child is allergic.

**At Our Hospital**
At Children’s Hospital Los Angeles, the Division of Clinical Immunology and Allergy combines treatment, research, education and outreach in the care of children with severe allergic disease. Often, the Division is called upon to help children for whom standard allergy protocols simply aren’t enough to keep them allergic reaction-free.

**Other Allergy Resources**
- [www.peanutfreeplanet.com](http://www.peanutfreeplanet.com)
- [www.bestallergysites.com](http://www.bestallergysites.com)

This site focuses on resources for a wide variety of food allergies.
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We are pleased to recognize individuals, organizations, corporations and foundations for their generosity during fiscal year 2011. This Honor Roll includes donors who contributed $1,000 or more in cash gifts, pledges, or pledge payments. We also are proud to recognize those who have contributed gifts of $150 to $999 in the Red Wagon Society Honor Roll of Donors, available at CHLA.org/HonorRoll.

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