



Imperial Moscow Orphan's House with a child's hospital:  
Est. in 1763, it is now the Scientific Center of Children's Health.



# Newsletter

## **EPA General Assembly 2013**

Presentation of the newly elected EPA Council

## **Clinical update:**

Vitamin D and calcium absorption and actions beyond

## **News from Europe:**

Reports and comments from the 6<sup>th</sup> Europaediatrics

**EPA Newsletter / Issue 18/ July 2013**



# Letter of the Editor:

## A time of change and renewal

Dear colleagues and friends,

After 18 issues and nearly 5 years of life, the newsletter can be considered consolidated. Over this period of time it has accomplished the aims I expressed in the editorial of the first number in January 2009. This can be summarized as facilitating quick, concise and true information. The life of EPA, clinical updates and news from our specific pediatric world have all been treated under this principle, which has not always been easy. Circulation has spread steadily up to the 50,000 recipients we have nowadays. Our latest achievement has been the Digital Object Identifier, DOI, prefix 10-11633, allowing the content of the EPA newsletter to be searched and above all referenced. Without the efficacy and quality of the technical support this progress would have been impossible.

After this intensive yet satisfying mission a change in the editorial leadership has been readily accepted. At the last Council Meeting (Athens, 29<sup>th</sup> March), Professor Julije Mestrovic, full professor of pediatrics and Head of the Pediatric Intensive Care Unit of the University Hospital of Split, Croatia, was elected as Editor and Professor Fügen Çullu-Çokuğraş, full professor of pediatrics and Head of the Pediatric Gastroenterology, Hepatology and Nutrition of the University Hospital of Istanbul, Turkey, as co-editor. This will guarantee the future of our newsletter in terms of pediatric quality and growth and we congratulate both of them and also all of us on their positive upcoming work.

As this issue was scheduled for publication before the Congress in Glasgow, I would just like to comment that we were given the opportunity to update our knowledge in the main clinical aspects of our daily work. However, nor were the preventive goals neglected as prevention in pediatric ages improves health further on in life. Also, the approach to pediatric subspecialties was considered with due interest as they represent a new situation that interacts with the clinical activity at the primary care level. Please see the detailed resume of the congress in this issue.

Furthermore, renewal is a normal step in every society, companionship or even corporation. This fresh air brings us new horizons and specific goals which are approached with renewed energy. In the General Assembly, the new election for Council officers took place and from here we send our congratulations to Prof. Leyla Namazova-Baranova as new President, to Prof. Julije Mestrovic as Vice-President, To Prof. Simon Lenton as Council member and to the re-elected officers Prof. Pettoello-Mantovani as General Secretary and Prof. Ehrich as Treasurer. Congratulations to all and I am sure they will run EPA successfully.

At this point of my farewell, I would like to thank all the staff who make the quarterly issue possible, all the colleagues who have been so brilliantly cooperative and particularly to all of you, devoted readers, the only true reason for this newsletter,

Manuel Moya

Manuel Moya  
Editor of Newsletter  
Vice President of EPA

*P.S. If you wish to receive an e-alert for new issues, all you have to do is send an e-mail to [epa-une psa@2eic.com](mailto:epa-une psa@2eic.com)*



*New times bring new opportunities and challenges. New leaders elected at the General Assembly 2013 will help EPA navigate safely into the future.*

***The European Paediatric Association (EPA/UNEPSA) held a General Assembly in the context of the 6<sup>th</sup> Europaediatrics on Friday, 7<sup>th</sup> June in Glasgow.***

The representatives of the member societies that attended the Assembly contributed with their votes to defining the direction and the immediate steps for EPA/UNEPSA.

The Council members were renewed after holding elections for five out of the eight positions. Prof. Leyla Namazova-Baranova (Russia) was elected as the new President of EPA/UNEPSA

The Council that currently leads the Association has the following composition:

- **Leyla Namazova-Baranova**, President (term ends in 2015)
- **Massimo Pettoello-Mantovani**, Secretary General (term ends in 2015)
- **Manuel Moya**, Vice-President (term ends in 2014)
- **Julije Mestrovic**, Vice-President (term ends in 2015)
- **Jochen Ehrich**, Treasurer (term ends in 2015)
- **Fugen Çullu Çokugras**, Councilor (term ends in 2014)
- **Simon Lenton**, Councilor (term ends in 2015)
- **Andreas Konstantopoulos**, Past President
- **Giovanni Corsello**, Ex-officio member, President of the 7<sup>th</sup> Europaediatrics 2015

The General Assembly also approved the applications from two new national paediatric societies, the **Russian Public Academy of Pediatrics** and the **Azerbaijan Pediatric Society** and both societies are now official members of EPA/UNEPSA. Last but not least, the Romanian Paediatric Society won the bid to host the **8<sup>th</sup> Europaediatrics Congress and Bucharest will play hosts to the flagship event of EPA/UNEPSA in 2017**. Bucharest known for its wide, tree-lined boulevards and glorious Belle Époque buildings is Romania's cultural and commercial capital.



*Left: Prof. Leyla Namazova-Baranova is the new President of EPA/UNEPSA. Right: Posing together with the president of the 6<sup>th</sup> Europaediatrics, Professor Terence Stephenson.*



*The EPA General Assembly took place as usual in connection to our flagship conference, Europaediatrics. This time it was in Glasgow, Scotland.*

## Adolescent medicine in European paediatrics

By Professor Russell Viner  
Professor of Adolescent Health  
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### *Paediatricians across Europe are beginning to wake up to the importance of adolescent health.*

We have been incredibly successful at what most of us see as the primary aim of paediatrics - improving the health of young children. Mortality rates for the under-fives fell 88-95% in nearly all European countries over the past 40 years. Young children come into hospital less, spend less time as inpatients and make fewer visits to paediatricians. Young children have particularly benefited from improvements in medical care and the 'epidemiological transition', meaning the conquering of infectious diseases over the last half-century, with disease burden shifting to non-communicable diseases and injuries.

At the same time, we now see fewer young children in the population in all European countries. Birth rates have fallen across Europe and our populations are aging, even in poorer countries. This has meant a shift in population from early childhood to adolescence – something demographers call a 'youth bulge'. Adolescents now make up around 13 to 20% of the total population of all European countries. There are now more in the second decade of life (10 to 19 years) than in the first decade (0-9 years) in most countries in Europe.

Yet at the same time as these changes have occurred, the burden of ill-health has been fallen little or actually increased among our young people. Adolescents have benefitted relatively little from the epidemiological transition, as infectious diseases have traditionally minimally affected teenagers. However the 'new morbidities' of injuries and non-communicable diseases such as diabetes, asthma, obesity, depression etc, particularly involve teenagers.

These changes have driven a shift in the burden of diseases in children and adolescents, with the burden and health need coalescing around two poles, neonates at the bottom of the age range, and adolescents at the top.

Paediatrics is the 'developmental' speciality, with our focus being on care of children during rapid growth and development. Yet adolescence is the second greatest time of development in the life-span. The great physiological drama of puberty produces changes in all organ and metabolic systems and is accompanied by dramatic brain and psychosocial development.

We have always had a focus in paediatrics on infants, and trained paediatricians well to deal with the very young. There is a need now to skill up our workforce to deal better with problems at the top end of our age range i.e. adolescents.

A further reason to focus on young people is that adolescence is the time when individuals adopt behaviours that will stay with them throughout life. This applies to self-management behaviours (such as how individuals manage their diabetes or asthma) to risk behaviours such as smoking and drinking. At age 10 years, parents are managing the majority of chronic conditions in their children and less than one per cent smoke tobacco. By age 15 years, young people manage the vast majority of their chronic disease regimens and 20-35% smoke depending on country. The behaviours initiated in adolescence track strongly into adult life, whether this be the way young people manage their diabetes or whether they smoke, drink or take drugs. These dramatic changes make early adolescence a very important time for healthcare, both prevention but also clinical services.

#### How do we define adolescence?

There are many different definitions in use and it is important to remember that adolescence is more of a developmental stage than a discrete time period. The most useful definition is probably at of the World Health Organisation (WHO), which defines adolescence as 10-19 years. However the exact definition matters little and should be varied depending on local circumstances. For many countries, 'children' are defined as those under 18 years, and thus adolescence may be better defined as 12 to 17 years. On the other hand, in the USA for example, adolescence is often thought of as encompassing young adulthood, extending from age 12 to 24. However, in some European countries, paediatric practice is largely or entirely limited to those under 14 years. Given the issues raised above, we would argue that this should be challenged.

#### What problems affect adolescents?

Young people suffer from persistent childhood problems and early onset of adult type disorders, as well as having a unique range of their own problems. Chronic diseases such as diabetes, asthma and epilepsy rise through childhood into adolescence, and are more common in teenagers than in children. Type 1 diabetes has its peak onset around age 12 years. Thus those paediatricians who manage chronic diseases will usually have a large proportion of adolescents in their practices. Mental health and behavioural problems are also a large source of burden, with depression, eating disorders and ADHD particularly prominent. Drug, alcohol and sexual health problems also emerge in mid adolescence, and pose a particular problem for paediatricians as our training rarely equips us to deal with these 'adult' type problems which are increasingly common in even early adolescents. Additionally, more non-specific problems such as fatigue, malaise, weight gain and somatic symptoms such as headaches and back-pains have a major peak in adolescence and pose a particular problem for primary care paediatricians.

#### Transition

The transition from child health to adult health services is a particular problem of adolescence, and is managed poorly in most disease areas in many countries. The time of transition can be traumatic for adolescents and their families as they lose trusted paediatric professionals and move into the cold unknown of adult medicine. Young people with chronic conditions who are relatively well may take this opportunity to 'drop out' of health care. A period of two or three years without medical supervision can be disastrous for

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disease control in diabetes or asthma, and there is a well-documented rise in the loss of renal transplants in the transition from paediatric to adult services. Thus working well with adult colleagues to make transitions efficient and welcoming is a key element of working with adolescents.

### Training and skills

Most paediatricians across Europe receive little training in adolescent health, although there are welcome elements of exposure to adolescent training in the European common trunk. While countries such as the USA, Canada and Australia have recognised adolescent medicine as a separate sub-speciality, this is not an approach we have taken in Europe. The majority of those who work in adolescent health in Europe believe that it should be a core area of training for paediatricians and for other physicians, particularly general practitioners and gynaecologists. In the UK, the Royal College of Paediatrics and Child Health has a 'special study module' in adolescent health, which paediatricians in training can undertake over 2 years to equip themselves with particular skills with young people.

The skills necessary to work in adolescent health are essentially those of a good paediatrician, i.e. the ability to communicate with the young person, together with knowledge of the issues and diagnoses of the appropriate age-group. What is particularly required to work with young people is knowledge of the specific developmental issues for this age group, a communication style that focuses on the adolescent rather than the family (e.g. seeing young people by themselves as well as with their parents), and an ability to communicate with young people in a non-judgemental and open manner. Health care settings that are youth friendly as defined by the WHO are important for adolescent care, particularly given that standard paediatric settings are designed almost entirely for young children.

A number of countries in Europe have significant groups interested in adolescent health, including the UK, Switzerland, Sweden, Norway, Spain, Denmark, Portugal, Italy and Germany, with growing interest in many others. Academic centres are active in Switzerland (University of Lausanne) and the UK (University College London).

A very important training resource is EuTEACH ([www.euteach.com](http://www.euteach.com)), a pan-European collaborative for training in adolescent health. The EuTEACH collaborative runs an annual summer school in adolescent health, now in its 12<sup>th</sup> year, which has trained over 200 professionals across Europe in the last decade. The EuTEACH website is an excellent resource for training initiatives across adolescent health, from clinical problems and communication through public health to advocacy and policy.

### Conclusions

Adolescents form a large proportion of the population and an increasing proportion of the practice of most paediatricians. Across the paediatric age-range, health need and burden is coalescing in infancy and adolescence. Paediatricians receive little training in adolescent health in most settings, at odds with the growing burden in this age group. Adolescent health should be at the heart of paediatrics across Europe.



# Vitamin D and calcium absorption and actions beyond

## A FACILITATING APPROACH

By Professor Manuel Moya  
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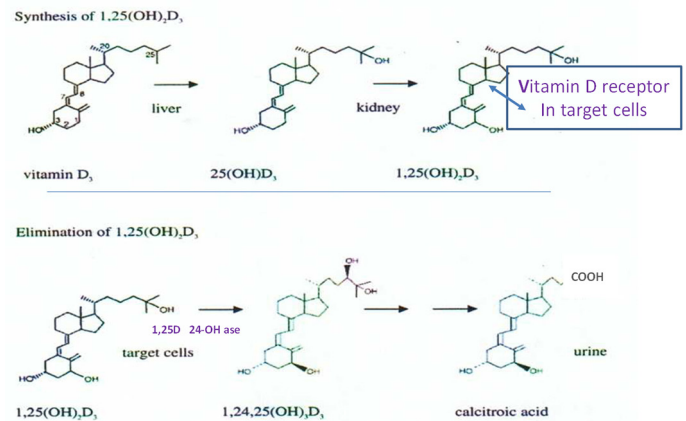
In the last four decades the awareness of the role of vitamin D has grown in such a way that from the original exclusive regulation of calcium homeostasis, it is now considered as an important factor in human health, after discovering the expression of the vitamin D receptor (VDR) in different tissues and organs. In this article we deal with basic metabolic paths of vitamin D and preventable dosages followed by a synopsis about the types of VDR and their role in the development of different diseases beyond calcium metabolism.

The biological circle of vitamin D (Figure 1) has two well known phases, metabolic and catabolic, separated by the union of the hormonal form of vitamin D<sub>3</sub> ie 1,25 dihydroxyvitamin D<sub>3</sub> (1,25 D<sub>3</sub>) with its specific receptor (VDR). In this circle it is worth considering that at the present stage we should always refer to vitamin D<sub>3</sub> because it is widely used as vitamin D<sub>2</sub> has only one third of the activity of that of D<sub>3</sub> (1). Plasma levels of 25 hydroxyvitamin D<sub>3</sub> (25 D<sub>3</sub>) clearly indicate the nutritional status of vitamin D<sub>3</sub>, being the normal range 15 - 80 ng/mL. Conversely, plasma levels of 1,25 D<sub>3</sub> that remain in the blood for only about 6 hours with a normal range of 20-50 pg/ml, depend on various factors (1,25 D<sub>3</sub> itself, 25D- 1-alpha hydroxylase, PTH, plasma Ca and P levels). Therefore, clinically risen levels could signal a calcium depletion by the body (2). In the catabolic arm, 1, 25 D 24 hydroxylase (24 OH ase) enzyme plays an important role because it is able to hydroxylate the lateral chain either of 25D or 1,25D, and this leads to 24,25 D<sub>3</sub> or 1,24, 25 D<sub>3</sub>. The latter not only has 1/10 of the potency of 1,25 D<sub>3</sub>, but it is also the precursor of the water soluble calcitroic acid that is excreted in the urine and thus completes the inactivation of the hormonal form. Now it is also clear that 24,25 D<sub>3</sub> is not an important metabolite for bone mineralization as was thought initially.

### Vitamin D receptor (VDR)

The polar metabolite of vitamin D (1,25 D<sub>3</sub>) modulates the expression of an ample range of genes located in different tissues or organs beyond the regulation actors of calcium metabolism. Due to the increased developmental consequences of gene alterations, it is worth summarizing a basic approach to the gene and its encoded protein, the VDR.

The chromosome 12 at the long arms (q12-q14) contains the human vitamin D receptor gene (hVDR, NR 1/ 1) made up of 62359 base pairs (3). It contains 11 exons, three of these (1A,1B,1C) are located in the 5' non-coding region producing three VDR mRNA spliced to form a mature mRNA from which VDR protein can be translated. This region also contains the promoters of hVDR. The remaining 8 exons encode the VDR protein according to the following sequence: exons II-III, the DNA binding domain (DBD); IV-V, the hinge domain; VI-IX, the ligand binding domain (LBD), the 3' end or untranslated region (UTR) is a non coding one but affects mRNA stability as will be seen. This gene encodes a



**Figure 1. Synoptic representation of vitamin D key metabolic steps.** The inflexion point is achieved when the active form binds the vitamin D receptor with the subsequent actions. From this moment the catabolic steps initiate leading to the urinary elimination of calcitroic acid

nuclear receptor, the VDR, which is a protein of 427 amino acids, that will act as a dependent ligand (1,25 D) transcription factor, therefore stimulating or inhibiting functions in target cells. The itinerary of 1,25 D, which is transported in plasma by the vitamin D binding protein (DBP), subsequently coupled in the cytoplasm with the VDR, up to the DNA specific zone known as vitamin D response element (VDRE), is rather complex (4). This union occurs under the form of a heterodimer with the retinoid X receptor (VDR/ DBD--RXR/DBD ). Basically the magnitude of this union is crucial for the regulation of the of 1, 25 D<sub>3</sub> itself. If low, renal 1-alpha hydroxylase is stimulated increasing the synthesis. If high, besides this counteraction, there is a stimulation of the D-24-hydroxylase (encoded by CYP24A1 gene) which is the first step of 1,25 D<sub>3</sub> inactivation (Figure 1). Apart from the above-mentioned VDR, a cell membrane receptor (VDR mem) for 1,25 D<sub>3</sub> that presumably is responsible for non genomic actions of the form 6-s-cis of the 1,25 D<sub>3</sub> also exists but it is beyond our present aim.

The gene alterations can be of two main types, either by mutations in the encoding domains such as those responsible for the Vitamin D dependent rickets type II, or by the appearance of polymorphisms. Polymorphisms are natural variations in a gene DNA sequence occurring with high frequency in the general population. They can affect a single base pair or long stretches of DNA. The first case, the most important here, is known as 'single nucleotide polymorphisms' or SNPs and they represent a replacement for instance of cytosine(C) by thymine(T) in a building block (nucleotide) of the DNA with a proportion of about one in every 300 nucleotides. Most commonly, these SNPs are found in the DNA between genes acting as biological markers of genes that can be related to disease. If the location occurs within the gene or in a nearby regulatory region, they may play a more direct role in disease after modifying the gene function, as for example can be seen in different bone mineral content, hypercalcemia, immune responses, etc. The list of VDR polymorphisms is open and growing as the genome-wide association studies (GWAS) are settled not only for locating genes associated with diseases but also for predicting individual responses to certain drugs or susceptibility to environmental factors. In this particular case the first ones described were the Cdx-2 polymorphism in the promoter region, regulating the expression of enhancer elements in the small intestine. The FokI (exon II) causes the protein to be extended by three amino acids which may affect ligand binding function(5). Polymorphisms have been found in intron VII and exon IX and particularly in 3' end with a still unclear clinical repercussion.

### Calcium intestinal absorption is the main function of vitamin D in calcium homeostasis.

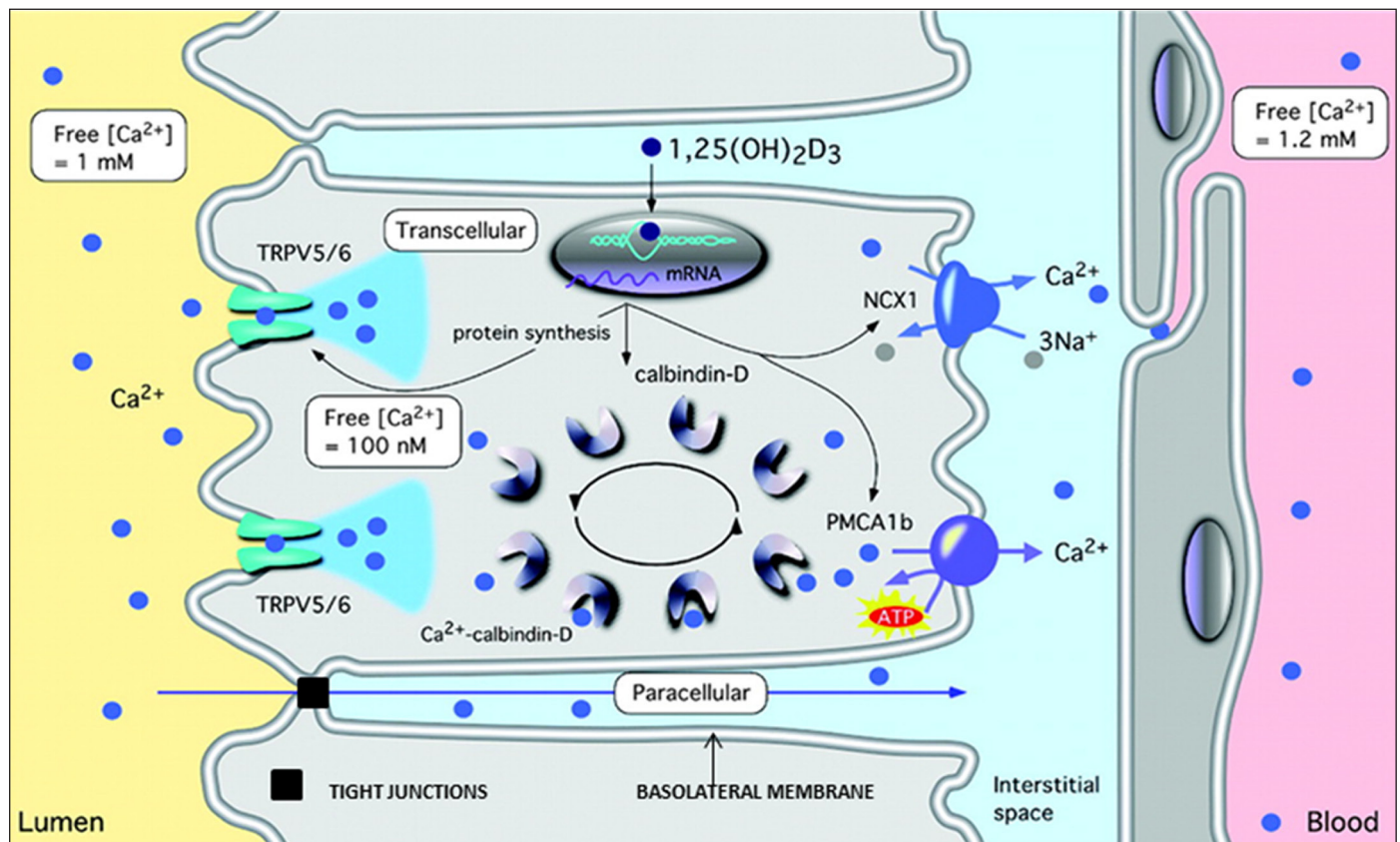
Calcium absorption takes place through two different mechanisms, the active energy dependent transcellular route and the passive paracellular route through the tight junction proteins located in the apical part of enterocytes (Figure 2). The transcellular route depends on the binding of the heterodimer VDR-RXR to VDRE of gene DNA, with the consequence of a series of protein synthesis that activate intestinal calcium absorption. One of them is the transient receptor potential vanilloid type 6 (TRPV6) acting as an efficient apical calcium channel, the movements of calcium once inside the enterocyte are carried out by the also synthesized calbindin protein (calbindin-D<sub>9k</sub>, in humans) being the most important the translocation to the basolateral membrane where the extrusion of calcium to plasma takes place by the intestinal plasma membrane pump (PMCA 1 b) that uses ATP as energy source. Recent experiences on knock out mice for TRPV6 and calbindin indicate that there may be associated proteins that can carry out their roles (6). The paracellular route works along the length of the small intestine and it is more active at the distal parts. The cecum and colon also express the VDR. This pathway is driven by the luminal electrochemical gradient provided the integrity of the of the intercellular tight junctions. Tight junctions (Figure 2) are proteins located between the apical and basolateral membranes of the enterocyte and regulate the movement of macromolecules but also ions as in this case. These proteins are made up mainly from claudins ( claudere, to close). There are more than 20 different types but

claudin-2 and claudin-12 are the most important for the paracellular calcium transport. This fraction of the transported calcium into the body is not negligible and is probably regulated also by the levels of 1,25 D<sub>3</sub>, not only through claudins that enhance the paracellular calcium diffusion but other tight junction protein channels (aquaporins and cadherins). This point can be summarized saying that 1,25 D<sub>3</sub> acts to increase calcium absorption in different intestinal segments maintaining the calcium balance and although the mechanisms are well known in the duodenum more distal parts will require further studies.

The complex mechanism of calcium absorption apart from the well known clinical situation of rickets, celiac disease, lactose free formulas &c is affected by at least by 12 polymorphisms or various SNPs combinations, and this chapter has just begun.

Preventable dosages of oral vitamin D<sub>3</sub>. Vitamin D deficiency is preventable but in many western countries has increased in the last decade (7). If vitamin D insufficiency occurs when plasma 25 D<sub>3</sub> is below 15 ng/ ml and deficiency (symptomatic) when below 10 ng/ ml, probably our policies should be modified in pregnant and lactating mothers, infants and children. Daily dosages of 400 - 600 IU (10 - 15 ug) are safe and more efficacious (8).

**Figure 2.** Once the 1,25 D<sub>3</sub> is coupled with its specific receptor (under the form of heterodimer with RXR) binds to vitamin D response element (VDRE) in the gene DNA, the synthesis of the transient receptor potential vanilloid type 6 and calbindin-D<sub>9k</sub> begins allowing the transcellular absorption of calcium. The paracellular route regulated by the protein complex of the tight junctions can be also related to 1,25 D<sub>3</sub>.





### Expression of VDR in other cells or tissues.

Besides the great number of binding sites in the gene DNA, the encoded protein, the VDR, expresses apart from the enterocyte in more than 40 different tissues or organs going from adipose tissue to uterus. One important fact related to this wide tissular presence is the expression in peripheral mononuclear cells (PMC), blood is an easier accessible tissue in comparison to target cells (enterocyte, renal tubular cells, neurons &c). After a rather complicated procedure (culture, Scatchard analysis) VDR can be quantitated, in table 1 results from some patients suffering from different types of metabolic rickets appear together with a normal control group and an interesting sample of PMC from umbilical cord (9). An important question is if the VDR quantization corresponds to that in target cells, in the case of calcium homeostasis it seems concordant (10). In individual cases these measurements are a practical option until genomic studies are more accessible.

Genomic-wide map of vitamin D receptor binding. This term comes

**Table 1**

	VDDR	FS	XLH	Umbilical Cord	Controls
N =	1	1	2	13	64
1,25 D pg/mL	107-231	200-215	82-97	89,1(26,5)	75,7(30,8)
VDR fmol/mg protein	<10	27,15	85-81	87-9(20,2)	92,8
VDDR II: Vitamin D dependent rickets type II; FS: Fanconi Syndrome; HLH: X-Linked hypophosphatemic rickets. All VDR measurement were done in treated patients, they do not represent basal values. Moya M (ref 9)					

after an important research group mainly based in Oxford University (11). Using a new DNA sequencing technology they were able to create a map of vitamin D receptor binding across the genome, discovering 2776 binding sites (ie VDREs) for VDR along the length of the genome. Also were identified 229 genes with significant changes in their expression in response to 1,25 D<sub>3</sub>. After genome-wide studies, it was found that VDR binding sites were concentrated in the GWAS intervals for some common diseases ie, near different genes associated with susceptibility to autoimmune or cancer conditions among other diseases (T1D, multiple sclerosis, Crohn disease &c). It is known the fold enrichment of VDR binding within this interval for 47 common diseases or individual traits (skin tanning, hair color, height...) occur versus the expected genomic features from reference sets. Certain polymorphisms located within VDR binding intervals were associated for example with systemic lupus erythematosus (SNIP rs13385731 in the first intron), T1D (SNIP rs947474, in intergenic region) or bone mineral density (SNIP rs9594738, in intergenic region) and so on. In general these alleles have modest effects on disease risk but can indicate the predisposition, the molecular basis and even some therapeutical approaches. The colorectal cancer (CRC) can be a good example, GWA has shown an enrichment of 4.0 fold ( $p < .0001$ ) of VDR binding in the interval associated with it. The increased number of copies of 1,25 D<sub>24</sub> hydroxylase in the gene locus CYP24A1 of the chromosome 20q13.2 would inactivate 1,25 D (figure 1), thus favoring CRC appearance (12). Other polymorphisms or enhancers of CYP24A1 can lead to similar results (13). In counterposition higher prediagnostic 25 D plasma levels are associated with improved survival in patient with CRC (14 Fedirko). According to this model one could think that vitamin D has a role in preventing cancer but the Institute of Medicine (15) found that the evidence that vitamin D reduces cancer incidence and related mortality was inconsistent and new trials should complete the present information.

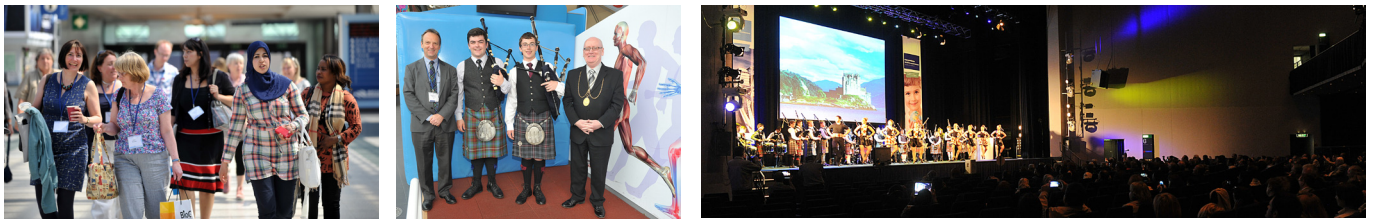
It can be concluded that from the initial action of 1,25 D- VDR in the enterocyte for optimizing calcium ( and phosphorus) absorption, the present knowledge indicates that this union regulates hundreds of genes codifying proteins involved in cell differentiation and

proliferation, the panorama has deeply changed.

### REFERENCES.

1. Armas LAG, Hollis BW, Heaney RP. Vitamin D2 is much less effective than vitamin D3 in humans. *J Clin Endocrinol Metab* 2004; 89: 5587-91.
2. Norman AW, Okamura WH, Bishop JE, Henry HL. Update on biological action of 1,25 (OH)<sub>2</sub> vitamin D3 (rapid effects) and 24R, 25 (OH)<sub>2</sub> vitamin D3. *Mol Cell Endocrinol* 2002; 197: 1-13.
3. Juntunen K. Functional and structural characterization of nuclear vitamin D receptor and its ligand binding domain. Oulu University Press 2002., <http://herkules.oulu.fi/> ISBN 951-4-6878-4.
4. Moya M. Receptores de la 1,25 dihidroxivitamin D. *Rev Esp Pediatr* 1009; 65: 225-30.
5. Ukaji M, Saito Y, Fukushima-Maekawa K, Kaoti N, Kaniwa N, Yoshida T. Genetic variations of VDR/ NR 1I1 encoding vitamin D receptor in a Japanese population. *Drug Metab Pharmacokinet* 2007; 22: 462- 7.
6. Christakos S, Dhawan P, Porta A, Mady LJ, Sth T. Vitamin D and intestinal calcium absorption. *Molecular Cell Endocr* 2011; 347: 25-29.
7. Davies JH, Shaw NJ. Editorial. Preventable but no strategy: vitamin D deficiency in UK. *Arch Dis Child* 2011; 96: 614-5.
8. Gallo S, Comeau K, Vanstone C, Agellon S, Sharma A, Jones G. Effect of different dosages of oral vitamin D supplementation on vitamin D status in healthy breastfed infants. A randomized trial. *JAMA* 2013; 309: 1785-92.
9. Moya M, Cortés E, Ballester I, Campello MJ. 1,25 dihydroxyvitamin D receptors in peripheral mononuclear cells (PMC) of patients with different types of rickets. *Abstract. Ped Research* 1994; 35 (4/2): 146.
10. Favus MJ, Karaukas AJ, Parks JH, Coe FL. Peripheral blood monocyte vitamin D receptor level are elevated in patients with idiopathic hypercalciuria. *J Clin Endocrinol Metab* 2004; 89: 4937-43
11. Ramagopalan SV, Heger A, Berlanga AJ, Mauger NJ, Lincoln MR, Burrell A. A ChIP-seq defined genome-wide map of vitamin D receptor binding: association with disease and evolution. *Genome Res* 2010; 20: 152-60.
12. Höbaus J, Hummel DM, Fetahu IS, Aggarwal A, Müllauer L, Heller G. Increased copy-number and nor DNA hypomethylation causes overexpression of the candidate proto-oncogene CYP24A1 in colorectal cancer. *Int J Cancer* 2013. Mar 5. DOI: 10.1002/ijc.28143.
13. Höbaus J, Fetahu IS, Khorchide M, Manhardt t, Kallay E. Epigenetic regulation of the 1,25- dihydroxyvitamin D3 24- hydroxylase (CYP24A1) in colon cancer cells. *J Steroid Biochem Mol Biol* 2012. Aug 20. DOI: 10.1016/j.jsbmb.2012.08.003.
14. Fedirko V, Riboli E, Tjornnerland A, Ferrari P, Olsen A, Bueno de Mesquita HB. Prediagnostic 25- hydroxyvitamin D, VDR and CASR polymorphisms and survival in patients with colorectal cancer in western European populations. *Cancer Epidemiol Biomarkers Prev* 2012; 21: 582-93
15. Manson J E, Mayne ST, Clinton SK. Vitamin D and prevention of cancer- Ready for prime time? *N Engl J Med* 2011; 364: 1385- 7.

# EUROPAEDIATRICS 2013 HIGHLIGHTS



And over 2,500 ovations to all paediatricians who jointly made it to this wonderful Europaediatrics. This flagship event of EPA remains a living example of how we can continue to keep European paediatrics evolving year after year, by working, learning and laughing together. This is incredibly important for identifying and overcoming the most challenging clinical conditions and cases in our daily environments. Especially in times of austerity and local hardship. Together we can and will always improve.



Here are some great memories for you to enjoy. A more formal report on the joint Europaediatrics and RCPCH conferences will follow in the coming issues of the Newsletter. For now: many thanks to all who contributed. As leaders, participants, speakers, exhibitors or organisers. A very happy summer to everyone - well done !



Important discussions during short breaks helped delegates share impressions of recent talks and to debate any controversial details. It was also a great opportunity to learn how colleagues in other countries are coping with the ever increasing rate of change in their clinical environments. New ideas emerged every day.



After years of hard work the first joint Europaediatrics - RCPCH Annual Conference finally became a reality. Proud stood the leaders from both EPA and from RCPCH, with the 6<sup>th</sup> Europaediatrics President Professor Terence Stephenson to receive the applause from over two thousand five hundred conference delegates.

## Scientific report of the 6<sup>th</sup> Europaediatrics

Dear friends and colleagues,

It was a great pleasure for me to act as President of the Scientific Committee of the joint Congress with The Royal College of Pediatrics and Child Health which took place within a framework of cooperation and hospitality.

The scientific balance was positive as regards the input of this latest edition of the Europaediatrics Congresses which started in Rome at the turn of the century. As Head of the Scientific Committee, it is perhaps not my place to make flattering remarks about the organization but data are objective and not influenced by the dedication we invested in this joint meeting in Glasgow.

Over 2,500 registered pediatricians attended the conference; there were 263 free papers, of which, as a result of their quality, twenty were presented orally. Although the acceptance standards were very high, only 11 % of the abstracts were turned down.

We had a series of updating sessions recognized for CME by the European Accreditation Council. It is worth signaling 3 plenary sessions with fascinating subjects that will affect the immediate future of pediatric care. Participants were able to enjoy the presentations of 110 distinguished speakers cleverly chaired in 84 conventional and poster sessions. The special symposia dealt with important aspects of child health. Among the regular symposia it is worth underlining the sessions on evidence based medicine or on familial hypercholesterolemia. Furthermore I would like to express my sympathy to the four colleagues who at the last moment for health reasons, bureaucratic problems or natural disasters were unable to attend.

My work, although heavy (more than 2000 emails in the in-tray over the last twelve months), has been fascinating. The meetings to assess and decide subjects and sessions were inspiring but particularly the contact with the speakers and chairs made me feel that my friendships have blossomed. The opportunities I have had to be in contact with all of you have also been positive and charming occasions.

In this concise report I do not dare to mention specific names but I would like to express my gratitude to our PCO, to the RCPCH, to all my colleagues from the Council, and particularly to the 15 members of the Scientific Committee. If the Europaediatrics part has been successful, this is probably due to the fresh ideas they have come up with. I hope that you all really enjoyed this scientific part of the Congress in the wonderful city of Glasgow.

But the Congress would have been nothing without your presence. I thank you for your participation throughout and I hope you keep up the good work in Rome in 2015.

Manuel Moya  
Chair of Scientific Committee

## What delegates said

*in submitted on site feedback forms*

*77% rated the innovative aspects of the scientific programme as very good or excellent*

*79% rated the selection of speakers as very good or excellent*

*77% rated the relevance of this conference to their educational needs as very good or excellent*

*75% rated the overall quality offered by this conference as very good or excellent*

*75% rated the adequacy of topics covered as very good or excellent*

*74% rated the effectiveness of the conference for professional development purposes as very good or excellent*

*72% rated the programme structure and breakdown of sessions per day as very good or excellent*

*71% rated their overall satisfaction with this conference as very good or excellent*

## A comment on the 6<sup>th</sup> Europaediatrics

By Professor Andreas Konstantopoulos

Europaediatrics, the biennial conference of the European Paediatric Association, took place in Glasgow, United Kingdom on June 5<sup>th</sup>-8<sup>th</sup> 2013, jointly with the Royal College of Paediatrics and Child Health Annual (RCPCH) Conference, for the first time in its history. The doors of the conference center in Glasgow opened on June 5<sup>th</sup> to welcome more than 2,500 professionals from more than 60 countries from the world of Paediatrics.

The Scientific Programme included an exciting mix of joint plenary lectures, personal practice sessions, symposia, parallel lectures and meet-the-professors sessions. Over 90 prestigious speakers from all over Europe and beyond offered updates on key clinical issues and the latest paediatric science. Special mention to be made to a number of special combined symposia with well-established institutions, societies and associations including: the World Health Organisation (WHO), the International Pediatric Association (IPA), the American Academy of Pediatrics (AAP), the European Society for Paediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN) and the European Society for Paediatric Infectious Diseases (ESPID).

The 6<sup>th</sup> Europaediatrics has been awarded with 21 credits by the European Accreditation Council for Continuing Medical Education (EACCME).



**Full activity at Scottish Exhibition and Conference Centre during Europaediatrics 2013.** Top: Despite the alluring summer sun outside, Europaediatrics delegates did not hesitate to prioritise the lectures in paediatric practice. Middle photos: Well-attended sessions engaged paediatricians from all around Europe in discussions about best practice. Bottom: In the internet era, traditional bookstores are an increasingly rare breed. A good old book, however, remains the favourite reading source for many of us. A medical conference is the perfect place for inspirational shopping and investments in our home libraries.

## The Advanced Life Support Group (ALSG): Saving lives by providing training

*ALSG is a medical education charity and is a world leader influencing and providing innovative life saving training for everyone responding to medical emergencies. We achieve this by developing training programmes and running training courses supported by quality assurance and research and innovation in medical education. The ALSG paediatric family of courses ensure the safe and effective management of children and young people along the entire health care pathway internationally.*

ALSG courses are currently available in 37 countries on five continents and they are all appropriate to the environment in which the healthcare professional is working (Figure 1). Over 130,000 people have been trained through ALSG courses since this medical education charity was formed in 1990.

Non-standardised care risks lives

It is a startling fact that paediatric 'first contact care' provision remains inconsistent across Europe (Wolfe et al., 2013). The 2012 Report of the Children and Young People's Health Outcomes Forum stipulates that, "All those working with children and young people should have the right knowledge and skills to meet their specific needs."

### What we can offer:

In order to address these deficits, ALSG globally offers standardised, structured training packages, with a flexible approach to adapting education to meet specific local training needs.

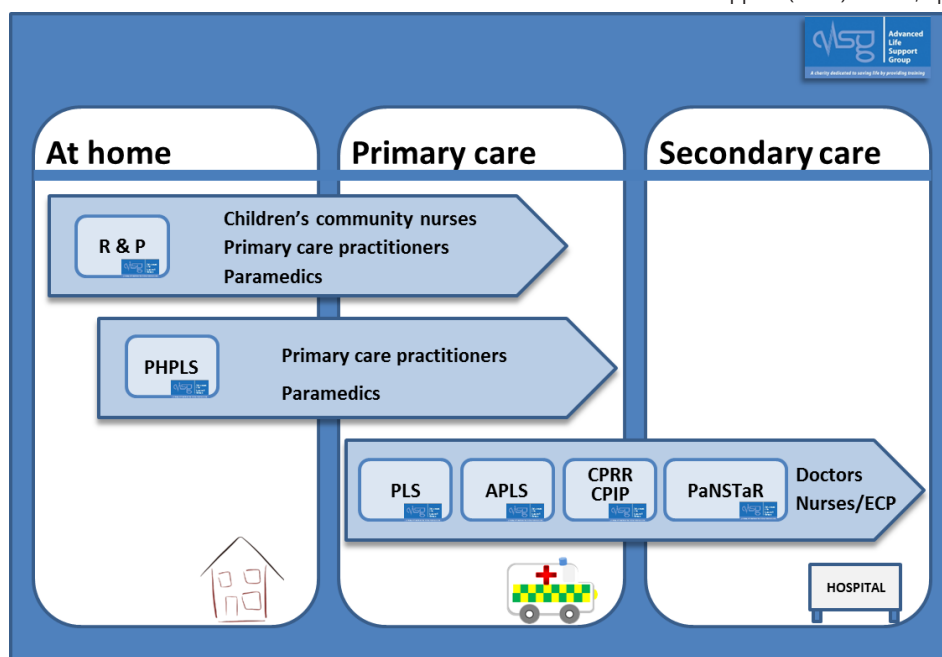
Our learning experiences are developed by expert clinicians and educators and supported by UK Royal College of Paediatrics and Child Health (RCPCH) sub-specialty groups. They follow a blended learning approach, with a course manual, e-modules, on-line assessment, face-to-face skills and simulation training. Human factors and instructor training are also an essential element in ensuring that excellent quality training is delivered. With access to the e-modules for four years, candidates are easily informed about changes in practice. CPD activities are offered on some of the courses and smart phone apps are due to be launched shortly.

Our paediatric family supports clinicians from the patient's home to the hospital and every step along the way:

The ALSG paediatric courses focus on recognition and response to acute illness and injury, safeguarding issues, in collaboration with the RCPCH and the National Society for the Prevention of Cruelty to Children (NSPCC), and transfer of children and young people. A summary of our paediatric family of courses with their potential clinical audiences is shown in Figure 1 and with further detail on the ALSG website ([www.alsg.org/uk/paediatrics](http://www.alsg.org/uk/paediatrics)).

To assist those working in primary care, our Recognition and Pathways (R&P) community course covers the essential elements to ensure that the healthcare professionals have the knowledge and skills to recognise, respond safely and implement care pathways - without risk - to the children and young people they are caring for. Many of these children and young people will remain at home; our Pre-hospital Paediatric Life Support (PHPLS) course provides healthcare professionals with the necessary knowledge and skills for those who require safe and effective emergency treatment at home and on the way to the hospital.

For clinicians managing children in acute and secondary care the recognised structured approach continues with Paediatric Life Support (PLS) courses supporting junior team members and professions allied to medicine (PAMs) in the immediate recognition and management of the seriously ill and injured child whilst more senior help arrives. The more senior clinical team undertake the Advanced Paediatric Life Support (APLS) course, appreciating a wider breadth and depth of issues on acute illness and injury.



Inevitably, neonates, children and young people will at times need inter- and intra-hospital transfers to receive their life-saving care in more specialised units. A safe, structured approach to the transfers is provided by the Paediatric and Neonatal Safe Transfer and Retrieval (PaNSTaR) course.

Safeguarding is everyone's responsibility and this is embedded within all of the paediatric courses. The Child Protection Recognition and Response (CPRR) course has been devised jointly with the RCPCH and NSPCC to train doctors in training in paediatrics, emergency medicine and general practice to recognise and respond to indicators of possible abuse and neglect. An on-line course Child Protection in Practice (CIPI) prepares senior trainees in paediatrics for their on-going child protection practice.

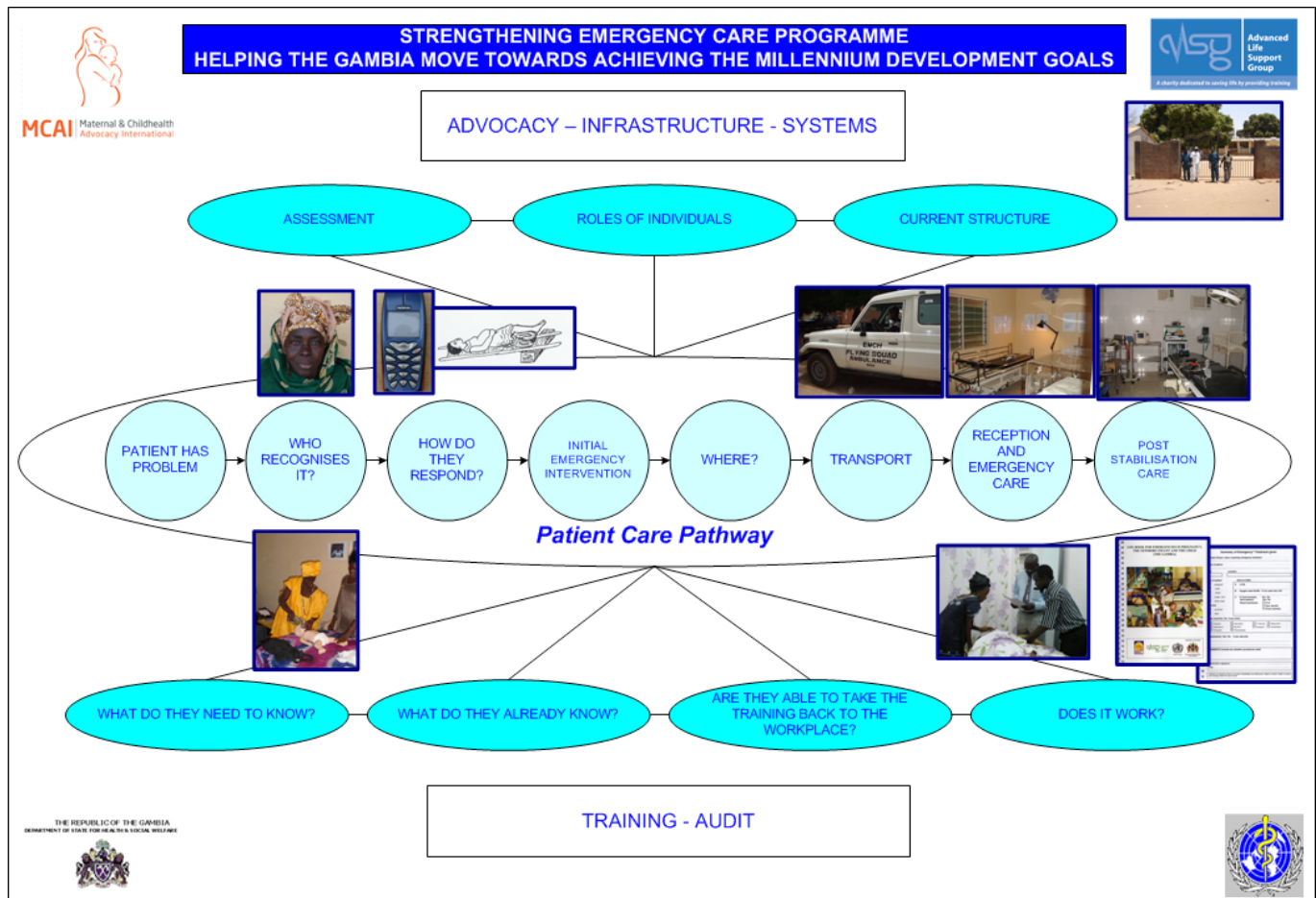


Figure 2: The SEC programme

**Figure 1: Courses along the entire healthcare pathway.** R&P – Recognition and Pathways; PHPLS—Prehospital Paediatric Life Support; PLS—Paediatric Life Support; APLS—Advanced Paediatric Life Support; CPIP – Child Protection In Practice; CPRR—Child Protection Recognition and Response – run in conjunction with RCPCH and NSPCC; PaNSTaR—Paediatric and Neonatal Safe Transfer and Retrieval

#### Strengthening emergency care in the developing world:

ALSG is also working in partnership with Maternal and Child Health Advocacy International (MCAI – [www.mcai.org.uk](http://www.mcai.org.uk)) towards achieving Millennium Development Goals 4 (to reduce the under-five mortality rate by two thirds) and 5 (to reduce the maternal mortality ratio by three quarters).

Our joint Strengthening Emergency Care (SEC) programme is a sustainable, whole system programme for the emergency care of pregnant women, newborn infants and children in countries where there is extreme poverty. This programme runs in The Gambia, Pakistan and Liberia. Since 2007, we have trained more than 800 doctors, nurses and community health workers in The Gambia alone. Figure 2 shows the elements of the SEC programme: advocacy; infrastructure; systems; training and audit and how they are implemented along the whole patient care pathway.

#### Does the ALSG approach improve outcomes?

It is notoriously difficult to separate out elements that contribute to improved outcomes.

Some evidence is, therefore, anecdotal, like these comments from our six-monthly feedback questionnaires, where we ask for examples of skills in practice:

***“A child with high temperature, tachypnoeic and tachycardic and poorly responsive. I was confident in assessing “the acutely unwell child” and was confident in my management. I would NOT have been confident prior to the course.”***

–Consultant in rehabilitation medicine

***“I do not have any paediatric training outside APLS. However am due to start as a paediatric trainee in August. During night shift, in a non-paediatric hospital, a mother turned up with her son who was having an acute asthma attack. A&E had closed. I was called by switchboard to come and assist. I was able to calmly assess the child and implement treatment while instructing switchboard staff to telephone for an ambulance to transfer the child to***

*the local A&E in the main hospital (where there was a paediatric department). As a result the child's symptoms and condition were improving by the time the ambulance crew arrived."*

-Foundation year 1 doctor in obstetrics and gynaecology

*"Two days after completion, whilst triaging in dept. a floppy baby presented to triage, all skills I had learnt were quickly utilised!"*

-Emergency department Sister

*"Recent child protection case which I felt much more comfortable dealing with."*

-Paediatric trainee

*"I was involved in a child protection case and the course helped me with logical handling of the case and gave me confidence."*

-Paediatric trainee

Other evidence is supported by statistics. Following the courses in the SEC programme, candidates are issued with logbooks where they can document any cases in which they have used the knowledge and skills taught on the course. An initial summary of outcomes from these resuscitations produced in 2009, showed that in 96% of cases the patient survived (Cole-Ceesay et al., 2010).

Data published recently in The State of the World's Children 2012 (UNICEF) on under-five and maternal mortality in the Gambia illustrates the difference we are helping to make:

- In 2006 the Under 5 mortality rate was 109, in 2010 this has reduced to 98
- In that same period the Infant mortality rate has dropped from 84 to 57
- That is a difference between 1 in 7 children under 5 dying in 2006 and 1 in 11 children under 5 dying in 2010
- In 2005 the maternal mortality rate was 690 and in 2010 had fallen to 360
- In 2005 the lifetime risk of death in childbirth was 1 in 32. This had reduced to 1 in 56 in 2010

Supporting your practice: ALSG in your workplace

If you are interested in participating in, or running, one of our courses – or even creating a new course to meet your specific training needs – we would love to hear from, and work with, you. ALSG saves lives by providing training and we would like to help you achieve the same in your practice.

#### Contact details:

Advanced Life Support Group – swieteska@alsg.org – www.alsg.org

#### References

1. Cole-Ceesay, R., Cherian, M., Sonko, A., Shivute, N., Cham, M. et al. (2010). Strengthening the emergency healthcare system for mothers and children in The Gambia. *Reproductive Health*, 7:21. doi:10.1186/1742-4755-7-21 <http://www.reproductive-health-journal.com/content/7/1/21>
2. Lewis, I. and Lenehan, C. (2012) Report of the Children and Young People's Outcomes Forum. <https://www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results>
3. United Nations Children's Fund (UNICEF). (2012). Children in an urban world. The state of the world's children 2012. <http://www.unicef.org/sowc2012/index.php>
4. Wolfe, I. et al (2013). Health services for children in western Europe. *Lancet* 2013; 381: 1224–34. Published Online March 27, 2013 [http://dx.doi.org/10.1016/S0140-6736\(12\)62085-6](http://dx.doi.org/10.1016/S0140-6736(12)62085-6).

**MORE THAN 400 LEADING EXPERTS SAY WE CAN ACHIEVE A POLIO-FREE WORLD.**

1988	350,000 CASES	125 COUNTRIES
2012	223 CASES	5 COUNTRIES

**GOAL 0 CASES. 0 COUNTRIES.**

**LET'S CHANGE HISTORY AND END POLIO FOREVER.**

The European Paediatric Association supports the hundreds of scientists, doctors and technical experts from around the world who launched the Scientific Declaration on Polio Eradication on 11 April 2013.

Today, the world is closer than ever to eradicating polio, with just 223 cases in five countries last year. To capitalize on this time-limited opportunity to finally end the disease, a wide range of experts have signed the declaration to emphasize the achievability of polio eradication and endorse the Eradication and Endgame Strategic Plan, a new strategy by the Global Polio Eradication Initiative (GPEI) to reach the end of polio by 2018.

The scientists and experts signing the declaration come from more than 75 countries and include Nobel laureates, vaccine and infectious disease experts, public health school deans, pediatricians and other health authorities. For additional information about the Scientific Declaration or to view a full list of signatories, please visit the Emory Vaccine Center Website.





Corresponding member of Russian academy of medical sciences L.Kolesnikova, academicians S.Kolesnikov, chairman of the Russian Federal Council V.Matvienko, Russian Minister of health V. Skvortsova, head of the cultural Guardian Council S.Medvedeva, academicians A. Baranov during the Solemn Opening ceremony.

## Russia honoured the 250<sup>th</sup> anniversary of its paediatric public healthcare system

More than 5,000 pediatricians gathered together in February 2013 in Moscow for the XVII Summit, organised by the Union of pediatricians of Russia.

This Forum was dedicated to the 250<sup>th</sup> anniversary of pediatric public health care system in Russia. 1763, 1<sup>st</sup> September is considered as a historic date in the formation of national pediatrics, when Russian Empress Catherine the Great signed the Manifesto of establishing the Imperial Moscow Orphan's House with a child's hospital. The Manifesto declared this institution forever to be state-owned.

Today the legal successor of it is the Scientific Center of Children's Health, successfully continues and develops the principles of state approach, preventive direction and unique educational system for

pediatric care in Russia. Traditionally the care for preserving and promoting the health of small citizens became lifework for many generations of Russian pediatricians. In 1927 pediatricians united to the professional society, which is now called the Union of Pediatricians of Russia which has branches in all regions of Russia. New members-pediatricians as well as associations of pediatric specialists join it regularly. 17<sup>th</sup> Pediatric Summit once again proved the Union's highest quality of scientific and organizational activities.

The scientific program was various and based on the principle of postgraduate CME. Colleagues had the opportunity to take part in a lot of theme pre-congress master-classes, symposia, round tables and debates on the most hot topics such as: "state of the art of the problem of perinatal infections" or "pneumococcal infections: the importance of vaccinating carriage children", or "current aspects of brain protection in children" and many others.



Chairman of the Executive Committee of the Union of pediatricians of Russian professor A. Baranov and deputy-chairmen professors L.Ogorodova, N.Volodin, L.Namazova-Baranova.



At the Summit venue area.



The moderators of the debates professors B. Blochin, V. Tatochenko, L. Namazova-Baranova.

With great satisfaction and appreciation pediatricians attended the unique lectures of the distinguished scientists professors S. Plotkin, E. Alden, M. Brady, A. Grom, D. MacIntosh, M. Petoello-Mantovani, J. Marston, J. Dekker and other speakers.

As usual the Russian paediatric meetings attracted the attention of WHO.

Thus, this year results and perspectives of the Health Behaviour in School-aged Children program was comprehensively discussed.

A huge interest of delegates was locked on the international round table "Education of pediatricians: past, present, future". The modern trends in medical education in Russian Federation and Unites States were in the main focus of discussion.

The representative delegation from University of Southern California and LA Children's Hospital led by Head of the Keck Medical School professor K.Puliafito, and director of the Hospital professor B. Polk generously shared their experience with colleagues from Russia, CIS countries, Great Britain, Czech Republic, Italy.

As professor E. Alden, the president of the American Academy of Pediatrics marked: Although we speak different languages, all of us are standing on guard of children's health. And it is important for us to know the results of research that open new horizons in treatment and prevention.



Dean of the Keck medical school professor K. Puliafito.



Professor S. Plotkin.



Professors E. Alden and M. Petoello-Mantovani during the discussion.

The Summit which is held every 4 years is the main authority for our professional association. During the 17th Summit our leader professor Alexander Baranov was unanimously re-elected as the chairman of the executive committee of the Union of pediatricians of Russia. And the most relevant directions of our future activities for next 4 years were determined. And now we are full of enthusiasm and energy to implement them.



The international round table "Education of pediatricians: past, present, future".

# The program Nati per Leggere



By Alessandra Sila, educator, national coordinator NpL

Nati per leggere (Born to read) is a program to enhance the inclination to read in children from a very early age. Nati per leggere, born in 1999, is promoted by the professional and cultural organizations of librarians and paediatricians: Associazione Culturale Pediatri (ACP), Associazione Italiana Biblioteche (AIB) and Centro per la Salute del Bambino (CSB). The Associazione Culturale Pediatri puts together 3000 Italian paediatricians on cultural grounds. The Associazione Italiana Biblioteche links more than 4000 librarians, libraries, information services. The Centro per la Salute del Bambino is a non profit organization engaged in training, research and solidarity towards childhood.

## Description of the project

Nati per leggere is a nationwide program which aims at constantly involving the community in order to give children a better chance to develop from an intellectual and emotional point of view. The cognitive child's development is strongly stimulated by parents through simple activities such as reading aloud to them and creating of a familiarity with books and reading from a very early age. Besides, reading children a story is an emotionally involving activity for both parents and children, because it ensures exclusive quality time together. Looking at the same pictures, imagining the same situations at the same time, sharing emotions creates pleasant moments of very rewarding empathy for both.

**The organization of the project** is based on a strong decentralization, on the establishment of a network which aims at becoming ever more widespread in order to reach the greatest possible number of local realities. The network includes librarians, paediatricians, educators, teachers, associations willing to put their energies into the project. At a local level a commitment is undertaken to implement the project with the greatest flexibility and adaptation to the different situations. There are more than 500 local projects covering about 35% of the national population, with the participation of 8000 professionals among librarians, paediatricians, social/health professionals, nurseries' and playschools' educators. The national committee, composed of 5 librarians and 5 paediatricians, takes care of conforming local actions to the inspiring principles of the program, looking after public relations and communications at a national level, especially as regards editing the project web pages ([www.natiperleggere.it](http://www.natiperleggere.it)), Quaderni ACP ([www.quaderniacp.it](http://www.quaderniacp.it)), the publication of informative and promotional material, handling the mailing list [nplbib@aib.it](mailto:nplbib@aib.it) which links over 2000 people interested in the project.

**The training of the local project promoters** is one of the most important tasks of the national committee. Training is essential to create a common language among people of different professional and cultural background, first of all librarians and paediatricians but also social and health workers, teachers and other people of the local community who will be involved in locally setting up and coordinating

a network of interventions. Another important activity of the national committee is caring for and producing bibliographical tools to guide readers among the publishing novelties; in 2001, 2003, 2008 and 2012 four Nati per Leggere bibliographies "Nati per leggere: una guida per genitori e futuri lettori" (Born to read: a guide for parents and future readers) were published. Nati per Leggere has stimulated a great activity of selection and suggestion of the best books for children under 6 both at a national and local level. This activity has also been oriented towards increasing and updating the library collections for children, kindling an interest in many libraries and in public opinion for the need of public cultural services for children.

**The relationship with booksellers and publishers** is a very important aspect for Nati per Leggere. A catalogue of good books at a special price exclusively for NpL local projects is available to support the local projects in order to let the pediatrician to give a book to children as a gift at the well child visits. One of the books, the baby-book "Guarda che faccia!" edited by two paediatricians, was distributed till now in about 125.000 copies all around Italy. The same book was translated in croatian for the program in Dubrovnik.

But libraries could also activate a permanent monitoring of children's publications and its readers' appreciation, being a context where books and readers meet free of any commercial interest. From this point of view the bibliographical control exercised through the bibliographic guidance and selection should influence the availability of the suggested books, in order to develop a catalogue choice more oriented to readers' needs and a quality offer.

Nati per leggere strategy to reach the goal is to set up local working groups, supported by public libraries and paediatricians, which are involved in raising awareness about importance of reading to children among all families so that reading is perceived as a cultural and social improvement for children and indirectly for all the adults implied.

**The family paediatrician** has: a strategic and positive role, as he/she reaches children belonging to all social groups and parents have full confidence in him/her; an early and unique contact with all newborns; a real interest in the good growth of the baby; a continuous and regular contact (by contract with the National Health System he/she carries out well-child visits for the first 5 years of the child's life); a good knowledge of the family. Where paediatricians are active parties in the project (around 700, which means the 10%), the most suitable moment to communicate to parents the importance of stimulating an early literacy seems to be during the paediatric check-ups, which are expected to take place from birth to 5 years of age. The paediatricians gives the Nati per leggere materials and advises families to visit libraries regularly. The repeated and personal contacts (relationship) between the paediatrician and the family facilitates the transmission of information on the importance of early reading, which should be further strengthened in all possible environments starting from libraries.

**Public libraries** can offer great and effective opportunities to those who endeavour to attract potential or sporadic readers towards reading and consolidate inconsistent habits. Public libraries are in fact the suppliers of continuous learning available to all citizens; among their priorities they attempt to propose reading as an experience free from duties and interference, through a wide and diversified offer. The librarian knows books and how to make children love them; reaches pregnant mothers and can "bring the library" to health centres where prenatal courses are held; is in contact with the nursery schools and jointly with them can organize "book parties" and promote open meetings for all children. Reading volunteers in the libraries, in the waiting rooms of doctors' offices and hospitals, read aloud to children,

showing parents and children the pleasure and techniques of looking at books together.

Nati per Leggere has produced national materials which can be given to families (a leaflet with suggestions on how and what to read to children and bookmarks) and to professionals (a brochure with a complete presentation of the project and the materials available).

#### At national level we have developed:

- *A partnership with publishers and experts* in order to let local operators have more good titles suitable at low prices; now we have 22 titles on the special Nati per Leggere catalogue <http://www.natiperleggere.it/index.php?id=20>
- *A new edition of national bibliographies* (with the selection of new titles for littlest until 6) and in order to support training for local projects; work is developing on a regional basis with regional groups, like in Emilia Romagna, Lombardia, Veneto
- *The national prize Nati per leggere* <http://www.natiperleggere.it/index.php?id=9>: the aim of the prize, sustained by Piedmont Region, the town of Turin, the Foundation for the book, the music and the culture and of course by the NpL National Committee, is to stimulate a higher quality production of books for smaller children (aged from 0 to 3 years) and to reward the activity of the many local projects which don't have large economic support. The prize received for the first three edition a special recognition from the President Napolitano.
- *The video Il progetto Nati per Leggere* shoots some daily situations: mothers and children sharing books, paediatricians talking to mothers about books and how to begin to read with their babies, parents talking about the experience of reading with their children.
- *The videoclip "La sua storia comincia dalle tue parole. Leggere insieme, crescere insieme."* (His story starts from your words. Reading together, grow up together) <http://www.natiperleggere.it/index.php?id=188>

Examples of concrete actions of partnership with local agencies and creative reading projects: providing multilingual information to local communities including more and more families with languages different from Italian. Some counties have begun to do it, like Emilia Romagna [http://www.bibliotecheromagna.it/main/index.php?id\\_pag=53](http://www.bibliotecheromagna.it/main/index.php?id_pag=53) and Piemonte <http://www.regione.piemonte.it/cultura/cms/nati-per-leggere-piemonte.html>

- involving preschool institutions teachers and voluntary trained readers in special "Little stories week" in twin cities of the World Book Capital, Turin and Rome.

**The subscription to Nati per leggere** is deliberately bureaucracy-free, it is enough to fill the online form at <http://www.natiperleggere.it/index.php?id=13>. The condition required is to share the mission of the project and the willingness to support locally the activities to promote and enhance the experience of reading within the family, making parents and all the adults who take care of early childhood aware of this initiative.

#### The financial support

The most important public Institution that gives financial support to Nati per leggere is the "Centro per il Libro e la Lettura" of the Ministry of Culture at national level and at local level the Province (30%) followed by the City Council (23%). Banks and Foundations provide funds in the 10%.

#### Research: monitoring the reading attitudes

23% of the pediatricians involved in Nati per leggere took part in a study that monitors the parents' reading attitude. The study was based on a questionnaire administered to parents during the well-child visits

to children between 6 months and 6 years, before and after the Nati per leggere intervention. ([http://www.natiperleggere.it/fileadmin/user\\_upload/documenti/Ronfani\\_La\\_promozione\\_della\\_lettura\\_ad\\_alta\\_voce\\_in\\_Italia\\_2006.pdf](http://www.natiperleggere.it/fileadmin/user_upload/documenti/Ronfani_La_promozione_della_lettura_ad_alta_voce_in_Italia_2006.pdf))

#### Collaboration with the Government

Nati per Leggere was awarded a prize by the Ministry of Culture as "Best national reading and book promotion event in 2001" and the prize "Premio Miglior Amico della Famiglia" in 2011. Now a collaboration with the Centro per il Libro e la Lettura will promote NpL in 5 provinces and a region to all newborn.

## BORN TO READ



#### International

International collaborations and sharing of experiences help us to be more effective in promoting early literacy. Nati per Leggere is especially grateful to the American project Reach Out and Read <http://www.reachoutandread.org> that inspired our action. We also helped our colleagues in Spain to get started with a similar program "Nascuts per llegir" <http://www.nascutsperllegir.org>, in Switzerland <http://www.natiperleggere.ch/buchstart/it/kontakt/index.asp?navanchor=2510902>.

In Croatia the collaboration started in 2008 thanks to the interest of dr. Radonic' and the mayor of Dubrovnik. We had the pleasure to present the scientific backgrounds and guidelines of Nati per Leggere program to the city. In Croatia the program is called "Rodeni za citanje". They translated and printed the book "Guarda che faccia" (Gledaj ova mala slatka lica, Giunti Kids publisher) for all the newborn in 2009 and in 2010 we translated another book for the age of two yrs old children from the special catalogue to use as second book "Vado a dormire" (Idem spavati, Editoriale Scienza Publisher). This year we will choose the book for the age of four years. (Information: OPCA BOLNICA DUBROVNIK - DJECJI ODJEL Mr.sc. Marija Radonic, dr.med. - marijarado@bolnica-du.hr).

In March 2013 we represented Italy in an international conference "Prepare for Life! Raising Awareness for Early Literacy Education" in Leipzig. The conference developed the Leipzig Recommendations on Early Literacy Education, a whole set of recommendations on how to improve Early Literacy Education (ELE).

The declaration recognizes the UNESCO definition on literacy as "the ability to identify, understand, interpret, create, communicate, compute and use printed and written materials associated with varying contexts. Literacy involves a continuum of learning in enabling individuals to achieve their goals, to develop their knowledge and potential, and to participate fully in their community and wider society." Based on the assumption that ELE is a prerequisite for any kind of skill acquisition, one has to acknowledge that early literacy is more than learning the alphabet.

**Having considered all aspects of ELE, the declaration calls for the full involvement of all relevant partners:**

**Politicians and Policy Makers:**

Poor literacy skills lead to impoverished lives and have an economic impact on countries. A central task for politicians and policy makers is to embed ELE programs into their education and social systems. Politicians must ensure appropriate and long-lasting financial in a cross-departmental approach (health, education and social issues).

**Donors and Fund Raisers:**

We must make the case to decision makers and funders that ELE is crucial for education and society and that investment will yield long-term returns.

**Professionals:**

Early childhood teachers, librarians and other professionals have a huge responsibility; we expect from them the highest standards and in return they must be paid appropriately. Libraries play a crucial role in ELE and should be welcoming places giving space and resources to families, including the very youngest children.

**Volunteers:**

The value of volunteers lies in their ability to talk to target groups too often out of the reach of official channels. Honoraries should be trained and supported in their dealings with these hard-to-reach families. Volunteers bring personal commitment, and motivation to ELE. Training will strengthen their role and give impact to their work.

**Families:**

Parents and carers are a child's first teachers, thus their integration into ELE programs is central to their success. ELE has to begin as early as the birth of the child within the families. Empowering parents and carers must be a central task in improving literacy. This means raising awareness of themselves as role models in using language, communication and media, and encouraging them to be active, for example in reading aloud to their children every day. Parents should be empowered to provide a home rich in words and stories, and to inspire children to speak, to sing, to play, to move and to communicate. According to the cultural and social parameters in different countries, this should include all media used in the families and their surroundings.

**Society:**

Reading promotion needs awareness in all parts of society: politics, economy including campaigning at a large scale. Campaigning needs a wide range of partners and a defined benefit for all. Networks among health care institutions, social organizations, marginalized groups, churches etc. can provide multidimensional accesses to education, especially for disadvantaged environments. Multilingualism is an asset that should be encouraged and celebrated.

**Researchers:**

ELE is an interdisciplinary issue, for which various scientific perspectives need to be cooperating to achieve a common goal: Economics, Neurosciences, Psychology, Educational and Social Sciences, Media Sciences including research on digital literacy. Stronger bonds and meaningful connections between research and programs are needed.

In conclusion, ELE is everyone's responsibility. It has to start at the beginning of a child's life, to reach out to all children and to lead on to more advanced forms of literacy development. ELE is about our countries' futures.



## European Paediatric Association (EPA/UNEPSA)

Join the most extensive paediatric network in Europe!

Since the launch of the individual membership scheme, the European Paediatric Association (EPA/UNEPSA) embraces a constantly increasing number of individual members from all over Europe.

EPA/UNEPSA welcomes all doctors who are certified as paediatricians in Europe and are members of their respective National Paediatric Society/Association participating in EPA/UNEPSA.

By joining EPA/UNEPSA, you gain access to a network of 41 national European associations and open yourself to a new world of opportunities.

### Benefits

The individual membership is offered at a privileged 50 Euro annual fee and encompasses a set of benefits that aim to provide value to the wide community of European paediatricians.

- On line access to the The Journal of Pediatrics is a core benefit of individual membership to our association and we are excited by the prospect of making such a valuable resource widely available to paediatricians across Europe.
- Our members will enjoy reduced registration fees to Europaediatrics as well as to other events organised by our Association.
- The quarterly e-newsletter aims to be a source of current information relevant to the interests of European paediatricians.
- Finally, our members will find in our new website a valuable tool and resource

Individual membership is offered on an annual basis starting on the 1 January of each year and ending on the 31 of December.

You may apply on line for an individual membership. Please visit our website [www.epa-unepsa.org](http://www.epa-unepsa.org) for more details and to fill out a registration form.

We look forward to welcoming all of you in EPA/UNEPSA!

The JOURNAL  
of PEDIATRICS

Did you know...

that all individual members of EPA now also get a free subscription of The Journal of Pediatrics ?





## Upcoming conferences in 2013

### European meetings by EPA/UNEPSA Member and Affiliated Societies' Meetings

#### 109<sup>th</sup> Annual Meeting of the German Society for Pediatric and Adolescent Medicine

12-15 September 2013, Dusseldorf, Germany

#### VII Congresso Nazionale FIMP – Federazione Italiani Medici Pediatri

26-28 September 2013, Rome, Italy

#### 14<sup>th</sup> National Congress of the Portuguese Paediatric Society

3-5 October 2013, Porto, Portugal

#### National Congress of the Romanian Paediatric Society with international participation

25 – 28 September 2013, Targu Mures, Romania

### Other Paediatric Meetings

#### The 4<sup>th</sup> Annual Conference of the European Confederation of Primary Care Paediatricians – ECPCP

3-5 July 2013, Tel Aviv, Israel

#### International Congress of Pediatrics – ICP 2013

24-29 August 2013, Melbourne, Australia

#### 12<sup>th</sup> World Congress of Pediatric Dermatology

25-27 September 2013, Madrid, Spain

#### 8<sup>th</sup> World Congress on Pediatric Infectious Diseases

19-22 November 2013, Cape Town, South Africa

#### Excellence in Paediatrics 2013

4-7 December 2013, Doha, Qatar

## List of member countries 2013

### Albania

Albanian Paediatric Society

### Armenia

Armenian Association of Paediatrics

### Austria

Oesterreichische Gesellschaft für Kinder- und Jugendheilkunde (OEGKJ)

### Azerbaijan

Azerbaijan Pediatric Society

### Belgium

Societe Belge de Pédiatrie/Belgische Vereniging voor Kindergeneeskunde

### Bosnia and Herzegovina

Paediatric Society of Bosnia and Herzegovina

### Bulgaria

Bulgarian Paediatric Association

### Croatia

Croatian Paediatric Society

### Cyprus

Cypriot Paediatric Society

### Czech Republic

Czech National Paediatric Society

### Denmark

Dansk Paediatrisk Selskab

### Estonia

Estonian Paediatric Association

### Finland

Finnish Paediatric Society

### France

Société Française de Pédiatrie

### Georgia

Georgian Paediatric Association

### Germany

Deutsche Gesellschaft für Kinder- und Jugendmedizin (DGKJ)

### Greece

Hellenic Paediatric Society

### Hungary

Hungarian Paediatric Association

### Ireland

Royal College of Physicians of Ireland/Faculty of Paediatrics

### Israel

Israeli Paediatric Association

### Italy

Società Italiana di Pediatria

Società Italiana di Ricerca Pediatria

### Latvia

Latvijas Pēdiatru Asociācija

### Lithuania

Lithuanian Paediatric Society

### Luxembourg

Société Luxembourgeoise de Pédiatrie

### Macedonia

Paediatric Society of Macedonia

### Moldova

Moldovan Paediatric Society

### The Netherlands

Nederlandse Vereniging voor Kindergeneeskunde

### Poland

Polskie Towarzystwo Pediatryczne

### Portugal

Sociedade Portuguesa de Pediatria

### Romania

Societatea Romana de Pediatrie

Societatea Romana de Pediatrie Sociala

### Russia

The Union of Paediatricians of Russia  
Public Academy of Pediatrics

### Serbia and Montenegro

Paediatric Association of Serbia and Montenegro

### Slovakia

Slovenska Paediatricka Spolocnost

### Slovenia

Slovenian Paediatric Society

### Spain

Asociación Española de Pediatría

### Sweden

Svenska Barnläkarföreningen

### Switzerland

Société Suisse de Pédiatrie/Schweizerische Gesellschaft für Padiatrie

### Turkey

Türk Pēdiatri Kurumu

### Ukraine

Ukraine Paediatric Association

### United Kingdom

Royal College of Paediatrics and Child Health



## EPA Welcomes Corporate Partners

EPA is an association for medical professionals. Our network is a fantastic talent pool of 60,000 paediatric healthcare professionals, who every year share their brilliant questions and suggestions on how to best understand and improve general paediatric practice. EPA always responds to such important feedback. Importantly, however, to be able to address shared issues, unmet needs or to develop good ideas and exciting initiatives, even after prioritisation, we need external financial resources.

EPA has therefore developed a corporate partnership programme that allows companies to support our work provided they share our mission and values, and comply with our ethical principles and Guidelines for Relations with Industry. Jointly we can understand diverse issues better, and develop targeted activities to effectively meet paediatricians' needs for medical education, best practice guidelines, and interactive communication. By working, learning and developing together - by proactively combining our strengths - we can develop and improve the clinical standards, and ultimately also European child health.

EPA would like to welcome its corporate partners and acknowledge their support in the development of the following exciting initiatives:



### "Good Health begins with Good Hygiene"

EPA and Reckitt Benckiser (RB) believe that good hygiene is a key ingredient to good health and work jointly to educate the public on the benefits of adopting good hygiene habits, both personal, in the home, and to explain why good health begins with good hygiene.

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