

- d. Representation on hospital wide clinical committees
 - e. Research activities
 - f. Implementing new policies/procedures
 - g. Evaluating new policies/procedures
3. The process of utilizing CDEs
- A CDEs involvement in:
 - a. Community activities
 - b. Patient clubs
 - c. Regulatory affairs
 - d. Nursing education
 - e. Physician education
 - f. Medical resident/physician education in-servicing
 - g. Preceptorship of nurses

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Mentorship Program for Regional Endocrine Nurses

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British Columbia is a vast province consisting of a population that spans five regional health authorities and one provincial health authority. General care can be accessed within these health authorities; however, pediatric subspecialty care is mainly provided at our hospital located in Vancouver. This requires many families to travel long distances to receive subspecialty care.

The limited local access to subspecialty care and the burden of making visits to Vancouver impact the health outcomes of children living with chronic conditions outside of metropolitan Vancouver. Families face financial strain because of the cost of time off work, transportation, accommodations, child care, and food. From a safety standpoint, families also risk traveling in poor weather in the winter to maintain regular follow-up. This may cause families to postpone travel or decrease the number of visits to our hospital. A number of studies (Vierhout et al., 1995; Tyrer, 1990; Williams, 1989, as cited in Gruen et al., 2009) show that clinical outcomes are poorer when patients are not seen in follow-up regularly.

Current literature suggests that outreach clinics are beneficial in improving access to specialty care (Gruen et al., 2006), reducing costs of accessing care (O'Brien et al., 2001), and improving the proportion of patients living in rural or remote communities receiving guideline consistent care (Howe et al., 1992).

It is obviously challenging within a regional system of care to provide specialty level services, but with capacity building and increased support from our hospital within these communities, I believe that children and families throughout BC can receive standardized nursing care and experience improved health outcomes such as prevention of severe illness episodes and stability of condition.

At our hospital, we have developed a mentorship program to enhance the capacity of regional clinic nurses working with pediatric endocrine patients and families. In addition, we have made efforts to improve accessibility of hospital resources, standardize care by creating an online guide, and increase support to nurses in regional clinics by providing telehealth and in person in-services and telephone or telehealth consultations.

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A Multicenter, Observational Study of Girls with Central Precocious Puberty Treated With Histrelin Subcutaneous Implant

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Background: Gonadotropin-releasing hormone agonists (GnRHa) are the standard of care for treating patients with central precocious puberty (CPP). However, there is a paucity of long-term, posttreatment follow-up data for patients previously treated with GnRHa.

Aims: The aim of this study was to provide long-term data documenting the reactivation of the hypothalamic–pituitary–ovarian (HPO) axis in girls with CPP who have been treated with histrelin subcutaneous implants (Supprelin LA).

Methods: This is an ongoing multicenter, observational patient registry. Girls diagnosed with CPP by 8 years of age, who started histrelin implant therapy by 8.5 years of age, and who are either currently on or have completed histrelin implant therapy are eligible. For this registry, CPP diagnostic criteria include breasts at Tanner stage 2 or higher and at least one of the following: random luteinizing hormone (LH) ≥ 0.3 IU/L and estradiol ≥ 20 pg/mL; GnRHa-stimulated LH ≥ 4 IU/L; or GnRHa-stimulated estradiol ≥ 20 pg/mL. Patients are treated by the investigators according to locally accepted clinical practices. Height and data related to puberty including Tanner stages, menarche or resumption of menses, puberty hormone levels (including LH, follicle-stimulating hormone, and estradiol), and bone age are extracted from charts or recorded during routine visits. Predicted adult height is calculated using the Bailey–Pinneau method. Primary end point is time to menarche or resumption of menses after discontinuing histrelin therapy. Patients will be followed for up to 3 years from the time of last implant removal.

Results: Up to 150 girls are expected to be included in the registry. To date, 17 sites are participating, and 2 patients (age 7 and 9 years) have been enrolled. At baseline, both patients had a normal body mass index, and a Tanner staging breast score of 3. On-therapy data from the first set of patients in the registry will be presented. Any adverse drug reactions will also be discussed.

Conclusions: This is the first patient registry to assess the recovery of the HPO axis after discontinuing histrelin for the treatment of girls with CPP.

Clinical Implications: Data from this ongoing registry will help determine the effect of long-term continuous gonadotropin suppression in girls with CPP in regard to the timing of HPO axis recovery.

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Long-Term Efficacy of Growth Hormone in Short Japanese Children Born Small for Gestational Age

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Background: Approximately 5% of all newborns are born small for gestational age (SGA), below 2 standard deviation scores (SDS) for height and/or weight. Beneficial effects of long-term