Happy New Year DPS members!

It is with great pleasure that I announce this month’s Spotlight Interview! Dr. Stanley J. Dudrick took time to sit down for an interview with Joan Healy, MA, RDN, CNSC for a discussion on the relevance of nutrition and a fascinating review of some of the history of the development of parenteral nutrition. Dr. Dudrick was on the front lines and has a very interesting perspective. We know Dr. Dudrick is a true star in nutrition circles, but did you know he and his “IV feeding system” were featured in a 1978 story published in People magazine? Turn to page three to get a glimpse of how the world of nutrition support began.

I am also proud to announce that four of our Distinguished Dietitians will be receiving awards during the President’s Opening Session of Clinical Nutrition Week in Long Beach, CA on Saturday, February 14. Two outstanding Nutrition Support Dietitians will also be awarded the A.S.P.E.N. Fellow designation on Sunday, Feb 15.

If you will be attending CNW15, don’t miss the opportunity to congratulate the winners and meet up with your friends at the Dietetics Practice Section Community Forum on Sunday, February 15, 6:00-7:15 PM. Please stop by Hyatt Regency’s Ballroom F for this fun, interactive session with hors d’oeuvres, a cash bar, networking and a chance to “Ask the Experts” all your burning nutrition support questions and gain some new expert clinical pearls! Our DPS Leadership Council looks forward to seeing you there.

If you’re attending CNW15, we’d like to recruit YOU as a DPS Reporter. You’re guaranteed to take away even more from the sessions you attend when you write up a summary for publication in Frontier. For more details, see page 2.

I look forward to seeing many of you soon at CNW15!

Marianne Duda, MS, RDN, LDN, CNSC - DPS Section Chair
Call for CNW 15 Session Reporters

Will you be attending CNW 2015 in Long Beach, either in person or virtually? Would you be willing to summarize the content of one or two sessions you attend?

This is YOUR chance to get involved in the DPS! Reporting on a session you attend provides you the opportunity to reflect on the content you heard, follow up by reading some of the papers referenced, and summarize your final thoughts on the information presented. This process helps you retain the information and incorporate it into your own clinical practice knowledge and skill set. It also provides an informative and quick outline of the topic to share with fellow clinicians who may have been unable to attend the session.

Writing a summary is an easy way to get more involved in the Dietetics Practice Section and to share your skills, while enhancing our profession as a whole. Please consider being a Volunteer Reporter at this year’s conference.

To volunteer, contact Jessica at jessica.monczka@orlandohealth.com for more information and to sign up for your favorite sessions.

Studying to take the CNSC Exam in 2015?

Resources to help you prepare include:

- Books - A.S.P.E.N. Core Curriculum and Pediatric Core Curriculum
- Online Lecture Series - Clinician’s Compendium to Nutrition Support Therapy [http://www.nutritioncare.org/Continuing_Education/Self_Study_Programs/Clinicians_Compendium/]
- Online Library - [http://www.nutritioncare.org/Clinical_Practice_Library/]
- Live Seminars - CNW15 Pre-Conference Workshop: Nutrition Support Fundamentals and Review Course, Saturday February 14, 7:00 AM - 4:00 PM.

There is also a recent blog post on the A.S.P.E.N. website with tips on how to effectively study for the test and incorporate your daily knowledge into the studying process. Read more at: [http://blog.nutritioncare.org/study-resources-for-your-first-cnsc-exam-part-2-beyond-the-books/]
We have a special treat for this issue of Frontier. Joan Healey, MA, RDN, CNSC, spent some time this past summer interviewing one of the early leaders (and legends) in our field, Dr. Stanley Dudrick, and provides us with this fascinating summary of their conversation.

It was the early 1960s and Dr. Stanley J. Dudrick, first year surgical resident, was making rounds on a Monday morning with Dr. Jonathan E. Rhoads, Chairman of the Department of Surgery, at the Hospital of the University of Pennsylvania (UPenn). Patients were often referred to UPenn from other facilities that were unable to meet their complex surgical needs. In many cases, these patients came to UPenn after multiple surgeries and were in frail health. After a particularly stressful weekend when he saw three patients under his care succumb to their illnesses, the young Dudrick spoke to Dr. Rhoads of his feelings of self-doubt and discouragement. “I’m thinking that maybe I don’t have what it takes to be a surgeon. If I were smarter or better, we might not have lost them. I thought maybe I should leave surgery and go into something where I might be more effective,” recalls the world-renowned, but still humble, Dr. Stanley J. Dudrick fifty years later.

Dr. Rhoads would proceed to point out that the common denominator that caused these patient’s deaths was malnutrition. When Dr. Rhoads further explained that the conditions of these patients would not allow for feeding into their guts, the inquisitive Dudrick questioned whether they might have been fed intravenously. Dr. Rhoads countered that others had tried, but so far had been unsuccessful. He then offered Dudrick his assistance and resources in the laboratory to further study the issue. Dudrick agreed but requested time to continue his surgical residency and learn more about nutrition. “I didn’t know anything about nutrition - there was no formal coursework in nutrition,” he says.

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After his fourth year of surgical training, when he was more comfortable with his nutritional knowledge and had clearer goals about nourishing patients, Dudrick went into the lab. In pilot experiments, he fed patients peripherally with 2,500 mL dextrose and protein hydrolysate solutions. When intravenous diuretics were fortuitously introduced at about the same time, Dudrick was able to add these to the parenteral nutrition to remove accumulated fluid from the patients, and increase the volume infused to 5,000 mL per day. These initial solutions contained B vitamins and vitamin C. Lipids were not yet being used. Long term subclavian catheters had not been developed at this time, and experience with central venous catheters had been problematic.

About these initial experiments, Dudrick says “We were starting from scratch; we were just desperately trying to get people better. What this helped us realize was that although this was a step in the right direction, we really weren’t getting to goal feeding. We weren’t reaching their caloric and protein goals.” These conclusions sent Dudrick and his team back to the lab for his now famous beagle puppy studies. They understood they needed “incontrovertible” evidence of the safety and efficacy of feeding by vein, and decided to work with young animals to see if they could get them to grow solely with intravenous nutrition.

After some preliminary attempts at peripheral nutrition in adult dogs, Dudrick realized he would need to find a way to feed via a central vein. Working first with mongrel puppies, then recently weaned pedigreed beagle puppies, Dudrick relied on his surgical experience, trial and error, ingenuity, and the resources of UPenn to achieve his goals. Through his own research, help from the engineering departments and the valued counsel of Dr. Harry Vars, Professor of Biochemistry, Dudrick found a method for infusing higher concentrations of dextrose through a self-styled central catheter into the superior vena cava.

The initial goal was to see if they could get the animals to grow for a month. That was achieved easily and the goal eventually became one hundred days, then adulthood. At

Continued on the next page
this time, lipid emulsions were available but were in an experimental phase. After unfavorable effects in human studies, and midway through Dudrick’s experiments, the FDA recalled lipids.

Even in the puppies not receiving lipids, the parenterally fed puppies grew as rapidly as the orally fed control puppies and did not develop symptoms of essential fatty acid deficiency within the first one hundred days or so. The investigators theorized that the puppies had adequate fat stores from being fed in their first several weeks of life by their mother.

Dudrick’s experience with the beagle puppies was soon duplicated in humans. He initially used parenteral nutrition (PN) on several adults who were unable to be fed via the gastrointestinal tract. Soon after, he would be contacted to assist in the care of a baby girl born in New Jersey with a catastrophic congenital anomaly of the small bowel. The child would prove to be more analogous to the puppies of Dudrick’s experiments, and similarly demonstrated normal growth with the use of PN. When she developed essential fatty acid deficiency, and with fat emulsions still unavailable in the U.S., Dudrick was able to infuse fatty plasma donated by the child’s parents. He would do the same with subsequent babies until lipid emulsions were again available.

Dudrick’s contributions to nutrition extend beyond PN and subclavian catheters. “I was interested in nutrition - the best nutrition for people under any conditions - the best oral, the best IV, the best enteral.”

His work influenced the development of elemental enteral formulas. “Tube feeding got better as a result of PN. Once we did the PN, we knew we could modify tube feeding the same way. Early elemental tube feedings mimicked the components of PN,” he says. He also was involved in the development of space formulas used by astronauts, including John Glenn.

Dudrick is proudest of his role in increasing awareness of nutrition in improved patient outcomes. “I would say my most important contribution is that I demonstrated to the world, beyond a shadow of a doubt, the relevance of adequate nutrition with optimal medical and surgical results.”

As one who developed PN and has witnessed its evolution, Dudrick is uniquely qualified to comment on current PN practices. “There are a lot of things we have to change. The intravenous fat we’re giving is causing more trouble than good because people are abusing it. They’re loading people up on fat … do they think that’s not going to affect their C-reactive protein or inflammation? We need to stop giving fat acutely. We need to develop a fat emulsion that mimics the requirements… but that means we’re going to have to make them synthetically. Or, why not fatty acids? Why not just start from scratch…. but that means somebody has to demand it” says Dudrick.

Referring to reports of shortages affecting PN delivery, Dudrick laments what he sees as a loss of initiative and common sense regarding the business of medicine.

After attending the fifteenth anniversary Polish Society for Parenteral, Enteral Nutrition and Metabolism Congress this past June, Dudrick shared his observations. Of our

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European counterparts he says, “They’re working on better fat emulsions; they are already giving some intravenous dipeptides. They have a better attitude about how to solve problems—what they don’t have are the resources we have. Although we have a lot of brilliant people and we have a lot of innovation and creativity, we don’t have the heart and soul for doing the right thing for the right reasons.”

Dr. Dudrick’s most important contribution is not only in demonstrating the relevance of adequate nutrition in patient outcomes, but his challenge to medical researchers and healthcare practitioners, in an increasingly competitive environment, to strive for excellence and remember what is relevant to, and in the best interest of, the patient.

Personal Interview - Dr. Stanley J. Dudrick
Naugatuck, CT.
June 28, 2014

Submitted by:
Joan T. Healey, MA, RDN, CNSC
Morrison Healthcare
Danbury Hospital, Danbury, CT.

October 2, 1978 Issue of People Magazine - Featuring a story on Dr. Dudrick’s Intravenous Feeding System
Enteral versus Parenteral Nutrition in Critical Illness


Submitted by: Gabriela Quiroz Olguín M.Ed. RD, INCMNSZ, Mexico City

Overview

Nutritional support in critically ill patients can be delivered by the parenteral (PN) or enteral (EN) route. The interpretation of published meta-analyses of trials evaluating PN in critically ill patients has been controversial. EN is considered the preferred standard of care. However, recommendations rely heavily on physiologic rationale. Evidence pointing to benefit with EN and greater infectious complication risk with PN is not of the highest quality. The authors of this paper hypothesize that delivery through the parenteral route is superior to the enteral route.

A pragmatic, open, multicenter, parallel-group, randomized, controlled trial was conducted involving adults with an unplanned admission to one of 33 English intensive care units. Patients were randomized to be fed through either the parenteral (n = 1,191) or the enteral (n = 1,197) route, with nutrition support initiated within 36 hours after admission and continued for up to 5 days. The primary outcome was all-cause mortality at 30 days.

Inclusion Criteria

Patients who were at least 18 years of age were eligible if they were expected to require nutrition support for at least 2 days.

Exclusion Criteria

Patients were excluded if they could not be fed through either the PN or EN route, had received nutrition support in the past 7 days, had a gastrostomy or jejunostomy in situ, were pregnant, or were not expected to be in the United Kingdom for the next 6 months.

Major Results Reported by the Authors

By 30 days, 393 of 1,188 patients (33.1%) in the PN group and 409 of 1,195 patients (34.2%) in the EN group had died, with no significant difference between groups. There were no significant differences between the parenteral group and the enteral group for the 16 other secondary outcomes, including the mean number of infectious complications.

Author’s Conclusions

There is no significant difference in the 30-day mortality associated with the route of delivery of early nutritional support in critically ill adults.

Evaluation

The study was a well conducted, non-blinded, controlled and randomized trial. The institutions have preexisting protocols for the delivery of PN or EN, prevention of bloodstream infections and ventilator-associated pneumonia, as well as glycemic control. These protocols could be a potential factor for minimizing risks and complications associated with nutrition support.

The target nutritional value of 25 kcal per kilogram per day was not achieved for the majority of patients in the two study groups, although caloric intake was similar in the two groups.

Take Home Message

Early PN was found to be neither more harmful nor more beneficial than EN in this study.

Protocols for nutrition support delivery are necessary to minimize complications or delays in accomplishing nutritional targets.
Overview

Limited information is available on the long-term survival of patients receiving parenteral nutrition (PN) despite frequent use of this therapy. Short-term studies looking at PN effects after 4-6 months show high rates of mortality. Studies exist on various populations, including those with upper gastrointestinal cancer and malnutrition, but with little definitive conclusions. Research in this area does not provide clear conclusions, since PN is reserved for the critically ill who cannot tolerate sufficient energy and nutrients via the enteral route. Given the associations of PN with mortality, additional information is needed to understand the long-term effects.

A retrospective analysis of long-term survival with PN was completed by reviewing the lengths of hospital admissions and overall survival. Patients were placed on PN based upon the primary care doctor and Nutrition Support Team’s (NST) discretion. The hospital protocol stated that PN was to be started when there was inadequate nutrition for 5 or more days. There were 4 scenarios identified for PN use including inability to tolerate enteral nutrition, contraindication to enteral nutrition, inadequate enteral nutrition, or not-indicated use of PN. The primary physician, with input from the NST, deemed appropriateness of stopping PN support and presence of central venous catheter infections. A follow-up assessment was completed to assess mortality or last known contact date.

Results

There were 437 patients included in the study with a total of 537 episodes of PN. The median length of PN was 7 days. The average patient age was 60 years. Gender division was 55% men versus 45% women. The top indications for starting PN were presence of ileus or inadequate enteral feeds.

Main Findings

- Overall mortality rate was 42% in 1.5 years after first PN use
- Mortality within 30 days after initiation of PN was 13%
- Those requiring PN during >1 hospital admission had increased mortality of 60%
- Admission to ICU with PN use had a mortality risk of 62%
- PN complications occurred in 11% (catheter-related bloodstream infection being the main cause)
- Patients with BMI ≥ 25 had a 65% chance of survival compared to BMI <25

Personal Evaluation

This study was able to provide a fairly large sample size with a long follow-up duration of 1.5 years or more. Additionally, the study had a multidisciplinary NST which included a dietitian, gastroenterologist, pharmacist, nurse, and intensive care physician.

With close NST monitoring, there may have been decreased inappropriate PN use in this study. Unfortunately, the primary physician was able to make the final decision on starting PN even if the team did not agree. This study was unable to assess nutrition status of patients prior to starting PN so this factor was not considered.

Overall, the largest weakness of research in this area is the lack of control group, likely because of the infeasibility of using PN in a healthy population.

Clinical Application

The results of this study are difficult to interpret, since the PN group may have been a sicker population. Clinicians should carefully select appropriate candidates for PN support. NSTs are important to ensure appropriateness of PN at time of initiation, and optimization of PN regimen throughout the course of therapy.
 Pediatric Malnutrition


Submitted by: Hilary Pelligra, MS, RDN, LD

Background

In November 2014, Consensus Recommendations of indicators of pediatric malnutrition were published simultaneously by the Academy of Nutrition and Dietetics (AND) and American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.). Pediatric malnutrition is a fundamental part of the dietetics profession with more and more understanding that it is not isolated to developing countries. The statement issued begins by stressing the severity and growing prevalence of malnutrition especially in relation to the hospitalized population. Notably, the article indicates that malnutrition in the United States is observed most in the hospital thus routine screening and monitoring is essential. Without close follow-up, the presence of and increasing degree of malnutrition will further exacerbate primary diagnoses.

It is important to point out that the authors of this consensus statement define the purpose of this document to collaboratively establish indicators that can be used profession-wide to diagnose and document malnutrition.

Definition / Diagnosis

In the statement, malnutrition is also referred to as undernutrition. Pediatric malnutrition has several different organization-specific definitions but all address an inadequacy in energy and/or protein to support proper growth. When a clinician is trying to decipher the presence of malnutrition with only one data point, z-scores for weight-for-height/length, BMI-for-age, length/height-for-age, or mid-upper arm circumference (MUAC) should be utilized. With additional data points, clinicians have more parameters available to assess such as weight gain velocity, weight loss, decline in weight-for-length/height z-scores, or intake assessment compared to estimated needs.

Acute vs. Chronic Malnutrition

Parameters are included that describe the difference in diagnosing acute versus chronic malnutrition. Acute malnutrition typically is seen as being less than 3 months in duration and can either be the beginning of progression to chronic malnutrition or can be an acute exacerbation of a chronic condition. Additionally, acute malnutrition is often associated with weight status. Chronic malnutrition is seen typically as lasting longer than 3 months and normally presents as stunting. Z-scores are essential as well in distinguishing between acute versus chronic malnutrition. Several resources are cited in the paper that aid with calculating z-scores for anthropometrics.

Classifying Malnutrition

Identifying the degree of malnutrition from mild, moderate, to severe is also addressed. The included items to categorize malnutrition are percent desirable body weight, changes in trajectory growth, MUAC measurements, and z-scores.

Indicators

The document states eight indicators are recommended when assessing and diagnosing pediatric malnutrition:

1) Food/Nutrient Intake: This domain is the first method of assessing nutrition status and calls for detailed history and understanding of current intake. With thorough information, accurate assessment of potential nutrition deficits can easily be identified.

2) Assessment of Energy and Protein Needs: Indirect calorimetry (IC) remains the preferred method to assess needs; however the equipment is often not readily available. The second option is the usage of predictive equations with the understanding that these
are estimates. The equations with their indications and calculations are listed. The most frequently used equations are designed for use in the healthy population including the WHO equation, Schofield equation, 1989 RDA and 2005 DRI estimated requirements. Assessment of energy and protein needs must take into account current disease state.

3) Growth Parameters: Anthropometrics to monitor in ages 36 months or less include length-for-age, weight-for-age, head circumference-for-age, and weight-for-length. For ages 2-20 years, it is recommended to monitor standing height, weight, and BMI. There is a growing emphasis on the usage of z-scores versus simply looking at growth charts given that z-scores are able to not only compare data against normative values but also address the degree of change from the normative standard.

4) Weight Gain Velocity: The comparison of weight gain velocity to expected velocity is important in diagnosing malnutrition. Notably, the paper indicates that poor weight velocity (including weight loss or failure to gain) is independently and more closely related to mortality than any other parameter for diagnosing malnutrition.

5) MUAC: This measurement should be included in a standard assessment of nutrition status. MUAC is shown to be associated with BMI in children and adults and to be more reflective of acute changes in muscle and fat mass than BMI measurements in adults. MUAC measurements are able to help clinicians monitor nutrition status and growth in patients that have fluid shifts that reduce the accuracy of weight measures or disease-specific constraints to obtaining height measurements.

6) Handgrip Strength: The measurement of handgrip strength is easy to obtain given that it is a simple measurement to take and is cost-effective. Handgrip strength identifies changes in muscle function which reflects changes in nutrition status sooner than simple muscle mass. Further research is needed in the pediatric population to establish normative values but there is data suggesting reliability of this measure with various ages and disease states.

7) Proxy Measures as Substitutes for Traditional Anthropometric Measures: Following patients over time to assess growth is critical in order to identify growth deficits. Clinicians must learn alternate measurements to track growth when traditional measurements are not feasible to obtain.

8) Documentation of Tanner Stage: The last indicator recommended is monitoring puberty progression in relation to nutrition adequacy. Studies suggest a correlation with lower weights and heights with lower Tanner stages. However, relating Tanner stages to nutrition is somewhat limited because of the unknown effects of individual genetics on puberty progression.

Implications to the Profession

As malnutrition continues to be studied and further defined, clinicians must fine tune their own documentation to follow the diagnosing guidelines as they are updated. Supporting current recommendations helps present a consistent framework that can be applied and understood across healthcare facilities. The magnitude of data available showing the effects of malnutrition on mortality and hospital costs certainly supports the need for clinicians to educate themselves. With such a high proportion of malnutrition found in institutions, reassessment of the patient’s nutritional status throughout the hospital stay is necessary. Further research will be needed to understand malnutrition and validate tools used for diagnoses such as Tanner stage or handgrip strength, which are suggested in this consensus statement.
DPS Annual Meeting
Relax and network with fellow dietitians in a casual format,
Sunday 6:00 PM in the Hyatt Regency Ballroom F

Physical Assessment
Postgraduate Course 3: Fine Tuning Your Practice with Nutrition-Focused Physical Examination
Saturday 12:00-4:00 PM
Learn hands on examination skills to help you assess nutritional status at the bedside in this extremely popular pre-conference workshop.

How to Lead in the Field of Nutrition
President’s Address
Saturday 4:30-5:45 PM
39th A.S.P.E.N. President Dr. Teitelbaum, Pediatric Surgeon at University of Michigan, will discuss how we must re-prioritize our goals and objectives to ensure that we remain leaders in the area of nutritional research and innovation.

Microbiome
The Role of the Gut Microbiome in the Pathogenesis and Treatment of Obesity
Sunday 10:30 - 12:00 PM
This session features an excellent faculty with Dr. Tappenden, PhD, RDN, FASPEN; Dr. Mullin, MD; and Dr. Matarese, PhD, RDN, LDN, CNSC, FADA, FASPEN discussing one of the hottest topics in nutrition and should be an excellent review of the research and treatment options.

Blenderized Diets
Focused Learning Session: Blenderized or Pureed Diets via Gastrostomy Tubes
Sunday 4:00 - 5:30 PM
Get practical information to help you manage your home blenderized diet enteral nutrition patients in a casual round table format.

Objective Measurements of Lean Tissue
Dudrick Research Symposium
Monday 8:00 - 9:30 AM
Dr. Earthman, PhD, RDN will be leading this program that focuses on lean tissue’s central importance in acute and chronic illness, cutting edge measurement techniques, and the interrelationships between protein and lean tissue and how protein requirements are determined.
For a little fun at the end of the newsletter, solve this word search of nutrition topics of 2015. Many of these topics are scheduled for seminars and round table discussions at Clinical Nutrition Week in February, so we’re sure to hear more about them in the coming months.

BLENDERIZED
CYTOKINE
EMULSION
ETHICS
FAT
GLUTAMINE
HEALTHCARE
INSURANCE
INTEGRATIVE
LEAN
MALNUTRITION
MEDICARE
METABOLOMICS
MICROBIOME
PANCREATITIS
PERIOPERATIVE
PUBLICATION
REIMBURSEMENT
SARCOPENIA
SELENIUM
SIGNALING
TASTE
TISSUE

ECNARUSNIAINEBUN
MVTRAFZYOINOSLTX
ULIRXIDNTICINE
IMKTSUEETITGNNEM
NMELAPGILMNDMO
ESUTORTUGEAE
LMECATETENLDLSB
EORTUBAPIGIIIRO
SAINAMOKOLCNZUR
SVLTSOLEIAGEBC
EATNYTTAOARYDMI
MZEBYGNESMEESIM
PANCREATITISPEB
NOITACILBUPCVRH
HEALTHCAREUSSIT
Consider enriching the DPS and increasing awareness and communication between members by authoring a submission to the DPS Newsletter. There are a wide range of items that could be submitted.

- Share clinical pearls or newly developed algorithms, protocols, guidelines, etc
- Review a recent paper in an area of interest to you
- Provide updates on a discussion from the list-serv or A.S.P.E.N. Connect
- Announce awards or accolades for your peers or co-workers
- Notify of upcoming conferences and continuing education opportunities
- Share nutrition-related outcomes monitoring methods, data and reporting experiences
- Volunteer as a CNW15 Reporter

One of the main objectives of the DPS is for us to network and learn from each other. The more individual involvement we have, the more comprehensive and varied the information provided in the newsletter will be to the group. Please consider getting involved. Contact the newsletter editors or anyone from the leadership team with your ideas, and Thank You!

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**2013-2014 DPS LEADERSHIP COUNCIL**

Chair - Marianne Duda, MS, RDN, LDN, CNSC  
marianneduda@aol.com

Chair-Elect - Trisha Fuhrman, MS, RDN, LD, FADA  
nutrisha50@earthlink.net

Past-Chair - Michelle Romano, RDN, LDN, CNSC  
romano.michelle@mayo.edu

Membership Chair - Kerry Stone, MS, RDN, CNSC  
kassd1@sbcglobal.net

Editor, Newsletter - Jessica Monczka, RDN, LDN, CNSC  
jessica.monczka@orlandohealth.com

Marsha Stieber, MSA, RDN, FAND  
mstieberrd@msn.com

Elizabeth Bobo, MS, RDN, LDN, CNSC  
elizabeth.Bobo@nemours.org

Maura O’Neill, RDN, MBA, CNSC  
maura.oneill@walgreens.com