In 1986, the American Board of Pediatrics approved pediatric pulmonology as a separate subspecialty area with specific fellowship requirements and a board certification examination. The first examination was administered that year and within the next few years, 150 physicians were certified in pediatric pulmonology. Another group of physicians who had been primarily caring for children with cystic fibrosis (CF), complex asthma, and a variety of other related pulmonary disorders for a minimum 5 to 10 years (prior to the establishment of accredited subspecialty training programs) were “grandfathered-in,” and were eligible to take the certifying examination.

There were 1,031 board certified pediatric pulmonary specialists in the United States as of 2016; most of the clinicians practice in university-based medical schools and some are in private practice or managed care groups. Prior to the recognition of pulmonary as a separate boarded specialty, children with cough or wheezing and chronic or recurring respiratory difficulties saw their pediatrician. Pulmonary issues made up a substantial percentage of what a pediatrician saw on any given day or week. This is likely still the case, but in large urban areas with easy access to specialty care and ever-expanding “outreach” efforts by pediatric tertiary care institutions, specialists see many more children as a first entry to care and for subsequent follow up as well for pulmonary problems. Is this optimal and if so why?

Many would argue that the greatly expanded understanding of the pathophysiology and molecular and genetic basis of childhood lung diseases as well as the development of new therapies based on these discoveries position the specialist as the one best able to provide the optimal care for children with pulmonary problems. Parallel with this surfeit of new knowledge and expertise is the rise of the well-informed and savvy consumers—parents who are much more likely to seek a specialist for their child than they would have in the past if they think it is warranted. This leads to the dilemma that is debated by many: who should be the initial point of contact for a child with recurrent cough and wheeze, a positive newborn screen for CF, or a follow-up after a first emergency department visit for what has been called asthma, and who should provide the regular follow-up?

The issue of *Pediatric Annals* includes five review articles that to some extent address these issues; in particular they highlight the state of our current understanding of the child who is born prematurely and who develops chronic lung disease of infancy, the new developments in the diagnosis and care of children with CF, a review of common upper airway diseases, the presentation and management of congenital lung malformations, and an overview of some of the less common entities such as ciliary dyskinesia and interstitial lung diseases that affect the infant and older child. Asthma is a much more common pulmonary problem affecting children and the many aspects and controversies in diagnosis and management of asthma are reviewed in the first part of this two-part issue on pediatric pulmonology.1

As noted by Drs. Megan K. Tracy and Sara K. Berkelhamer in the first article, “Bronchopulmonary Dysplasia and Pulmonary Outcomes of Prematurity,” as ever-smaller and more premature infants survive the neonatal period, many have multiple problems of which pulmonary compromise is only one. These infants are often best seen until age 2 or 3 years (or at least as long as they remain on oxygen) by a neonatology follow-up clinic that works closely with pulmonary, neurology, nutritionists, and developmental specialists, but with close communication with the family’s pediatrician who often provides care for the infant’s siblings. In the same vein, as Drs. Danielle Goetz and Clement L. Ren indicate in the second article, “Review of Cystic Fibrosis,” the network of accredited CF centers that have a wide array of specialists...
have worked to provide care that has greatly improved outcomes and life expectancy, and have developed an expertise in prescribing innovative mutation-specific disease-modifying therapies. Care of children with CF is best when there is collaboration between the CF physicians and ancillary services and the pediatrician who will typically provide the well-child care, including immunizations. In the next article, “Common Pediatric Airway Disorders,” Drs. Pallavi P. Patwari and Girish D. Sharma review congenital airway lesions. In the following article, “Congenital Lung Malformations,” Drs. John Palla and Marianna M. Sockrider provide a similar review of common lung malformations that may present in the neonatal period or early infancy. These infants are often referred directly to pediatric ear, nose, throat specialists, pediatric surgeons, or pulmonary physicians, but it is important for pediatricians to be familiar with the presentation and typical course of these entities. They may well be involved in helping families make decisions as well as providing follow-up care. The final article, “Full-Term Neonatal Respiratory Distress and Chronic Lung Disease,” by Drs. Naema Chowdhury, B. Louise Giles, and Sharon D. Dell on rarer lung diseases serves to remind pediatricians that new diagnostic modalities and treatment options are available so that together with the specialist, they may help them to provide care for a child with puzzling symptoms that do not fit with more typical and familiar diagnoses.

**REFERENCE**


Disclosure: The authors have no relevant financial relationships to disclose.

doi:10.3928/19382359-20190325-02

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**About the Guest Editors**

**Lucille A. Lester, MD**, has recently retired from the faculty of the Department of Pediatrics at The University of Chicago where she was a Professor of Pediatrics, the Section Chief of Pediatric Pulmonary, and the Director of the University’s Cystic Fibrosis Center for many years. During that time, she saw the life expectancy of children with cystic fibrosis double and triple, and also oversaw the establishment of the Adult Cystic Fibrosis program at The University of Chicago.

She also served as the Director of the pediatric outpatient clinics. She directed clinical studies of new therapies for children and adults with cystic fibrosis and collaborated with faculty members in early genetic studies of multiethnic patients with cystic fibrosis, as well as participated in a major multiyear study on the genetics of asthma funded by the National Institutes of Health. She has contributed as an author to numerous publications, presented at national meetings, and has enjoyed teaching and mentoring medical students, residents, and fellows.

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**B. Louise Giles, MD, FRCPC**, is a Pediatric Pulmonologist at Comer Children’s Hospital, The University of Chicago. Originally a nurse, she obtained her medical degree (Honors) from the University of Western Ontario, London, ON, Canada, before completing her postgraduate training in pediatrics, pediatric critical care, and pediatric pulmonology at the University of Western Ontario and Duke University, Durham, NC.

Dr. Giles has been active in numerous education and patient advocacy projects since her first appointment at the University of Manitoba, Winnipeg, MB, Canada. Currently, she is the Program Director for Pediatric Pulmonology fellowship at The University of Chicago and serves as a core faculty advisor for the Pediatric Residency. Additionally, Dr. Giles has led the development of the South Side Pediatric Asthma Center (Chicago) and is developing a severe/complex pediatric asthma clinic. Dr. Giles also serves as a consultant for the Environmental Law and Policy Center (Chicago), which provides guidance and advocacy for protection of the environment. Active in research, she is studying whether knowledge of current air pollution changes activity or behavior in children with asthma and is exploring the genetic roots of asthma in children of African descent. She is on the Editorial Board of *Pediatric Pulmonology PREP* (American Academy of Pediatrics) and is an Examiner for the Royal College of Physicians and Surgeons of Canada (Pediatrics).

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