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Pediatric STEMI: *It's Not Just an Adult Problem in a Smaller Patient*

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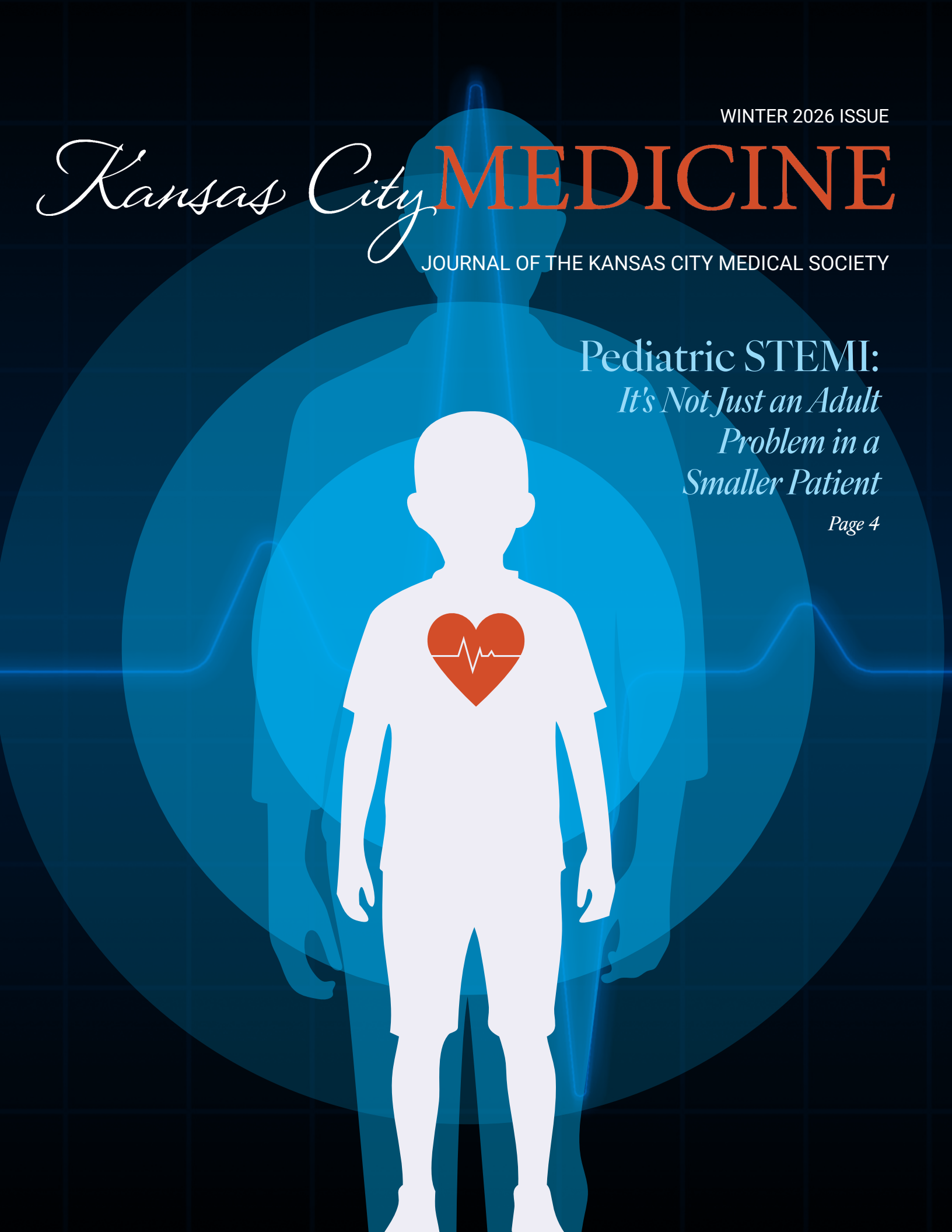

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Pediatric STEMI:

It's Not Just an Adult Problem in a Smaller Patient

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A Rare Diagnosis with High Stakes

ST-elevation myocardial infarction (STEMI) is a familiar emergency in adult medicine. It typically results from atherosclerotic plaque rupture and acute coronary thrombosis, and its management is guided by standardized protocols emphasizing rapid diagnosis and intervention. In children, however, STEMI is rare and often misunderstood. The underlying causes, clinical presentation, and appropriate response differ significantly from adult cases, yet many institutions still rely on adult-based algorithms when evaluating children and adolescents.

Our team reviewed nearly 1,000 pediatric cases flagged for myocardial infarction over a ten-year period at our institution and an associated adult hospital. Only 13 patients met the criteria for STEMI, and none had the classic adult etiology. Instead, congenital heart disease and structural coronary anomalies were the most common contributors. Our small sample size highlighted the rarity of this diagnoses in pediatrics but led us to wonder if our current STEMI response guidelines reflected the needs of this unique population.

> *The underlying causes, clinical presentation, and appropriate response differ significantly from adult cases, yet many institutions still rely on adult-based algorithms when evaluating children and adolescents.*

Congenital Heart Disease: A Common Yet Underrecognized Cause

One of the most significant findings in our study was the prevalence of congenital heart disease among patients presenting with STEMI-like symptoms. More than half of the cohort had known or newly diagnosed congenital anomalies. These included complex structural defects and coronary artery abnormalities that are not typically encountered in adult practice.

Three patients were found to have previously undiagnosed congenital coronary anomalies. These included:

- Anomalous left coronary artery arising from the pulmonary artery (ALCAPA)
- Anomalous origin of the circumflex artery
- Myocardial bridge involving the left anterior descending artery

None of these patients required an intervention in the cardiac catheterization lab. In one case, cardiac arrest occurred during cardiac catheterization requiring extracorporeal membrane oxygenation (ECMO) support and the patient was transferred back to our pediatric hospital on ECMO. Both of the other undiagnosed coronary anomalies also transferred back to our hospital; one required cardiac surgery, the other required implantation of a cardiac defibrillator.

These cases illustrate the complexity of congenital heart disease and its potential to mimic acute coronary syndromes. Importantly, these anomalies were not identified until after advanced imaging or invasive evaluation. This delay in diagnosis highlights the limitations of relying solely on adult-based criteria and protocols in pediatric patients.

For clinicians who do not routinely manage congenital heart disease, it is important to understand that these anomalies may not present with classic symptoms. Chest pain, syncope, or cardiac arrest may be the first indication of an underlying defect. Early involvement of pediatric cardiology and consideration of congenital causes can lead to more accurate diagnosis and safer management.

Catheterization Complications and the Role of Pediatric Expertise

Cardiac catheterization is a standard intervention in adult STEMI management, often performed emergently to restore coronary perfusion. In pediatric patients, however, the risks and benefits must be weighed differently. In our study, nine patients underwent catheterization. Three experienced cardiac arrest during the procedure, all of whom had congenital heart disease, and ECMO was initiated in each of these cases.

No percutaneous coronary interventions were performed at the adult hospital, despite initial transfer for STEMI evaluation. These findings raise important questions about the appropriateness of transferring pediatric patients to adult facilities for catheterization prior to advanced imaging to rule out congenital defects. While adult centers may have extensive experience with coronary interventions, they may lack the expertise needed to evaluate and manage congenital anomalies. The single catheter based coronary intervention in our cohort was performed at our pediatric hospital with coronary stent placement in a patient with known congenital heart disease and coronary stenosis. Pediatric catheterization labs, staffed by specialists in congenital heart disease, are more experienced in handling these cases safely and effectively.

The ECG is a Clue, Not a Conclusion

Every patient in our cohort had ST-segment changes on ECG. But unlike adults, where ST-elevation often points directly to coronary occlusion, pediatric ECGs are more nuanced. Lateral and diffuse ST changes were common, and in three cases, the final diagnosis was not ischemia but inflammation due pericarditis or myocarditis.

This is a critical point for clinicians: ST-segment elevation in children doesn't always mean STEMI. It's a signal to look deeper, especially for congenital causes or inflammation. Relying solely on adult criteria can lead to misdiagnosis or unnecessary interventions.

Protocol Revisions: A Pediatric-Centered Approach

Historically, our institution followed a protocol that prioritized rapid transfer to an adult hospital for suspected STEMI. This approach mirrored adult guidelines, emphasizing time-sensitive catheterization and intervention. However, our study revealed that this strategy may not be appropriate for pediatric patients.

Based on our findings, we revised our protocol to prioritize advanced imaging and evaluation at the pediatric hospital before considering transfer. This allows for early identification of congenital anomalies and ensures that decisions about catheterization and intervention are made with input from congenital heart specialists.

This change reflects a broader shift in thinking. Pediatric patients with STEMI-like symptoms should not be managed as small adults. Their anatomy, physiology, and underlying pathology are different, and their care should be guided by pediatric expertise.

What Clinicians Should Know

Whether practicing in a pediatric or adult setting, clinicians may encounter young patients with chest pain, ST-segment changes, or elevated cardiac biomarkers. Understanding the differences between pediatric and adult STEMI is essential for safe and effective care.

Key considerations include:

- ST-segment elevation in children often reflects congenital or inflammatory causes, not plaque rupture.
- Congenital coronary anomalies may be undiagnosed and can present as cardiac arrest, cardiac-related syncope, or ischemic symptoms.
- ECG changes in children require careful interpretation and should not automatically trigger adult STEMI protocols.

- Catheterization in pediatric patients carries unique risks, especially in those with congenital heart disease.
- Early collaboration between pediatric and adult cardiology teams improves diagnostic accuracy and patient outcomes

Conclusion

Pediatric STEMI is a rare but serious condition that requires a different diagnostic and treatment approach than adult myocardial infarction. The high prevalence of congenital heart disease among affected patients underscores the need for pediatric-centered evaluation and management. ECG changes should prompt further investigation, but not automatic activation of adult protocols. Catheterization carries significant risks in this population, especially for patients with congenital heart disease.

For clinicians across specialties, recognizing the unique features of pediatric STEMI is essential. By tailoring protocols to the pediatric context and involving congenital heart specialists early, we can improve outcomes and avoid unnecessary interventions.

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The authors declare no relevant financial relationships or conflicts of interest related to the content of this article. Artificial intelligence was used in accordance with the Journal of the American Medical Association (JAMA) guidelines to assist with language editing and improving clarity. The author reviewed and verified all AI-assisted content and assumes full responsibility for the integrity and accuracy of the manuscript.

> *Pediatric STEMI is a rare but serious condition that requires a different diagnostic and treatment approach than adult myocardial infarction.*

Auto Immunization Updates

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The contribution of vaccines to improving global public health cannot be overstated. Vaccines prevent an estimated 2 to 3 million deaths each year from pertussis, tetanus, influenza, and measles.1 As our world evolves, vaccine recommendations are continuously evaluated and adapted to keep pace. International travel, shifting weather patterns, and human exploration into previously uninhabited regions of the planet are just a few of the many factors which can lead to exposure to new pathogens. Consequently, vaccine guidance undergoes continuous updates as new vaccines and technologies are developed. These updates serve multiple purposes: addressing emerging infectious threats, incorporating improvements to existing vaccines, and responding when familiar diseases resurface. Additionally, recommendations are refined when research reveals new benefits of vaccination beyond infection prevention.

New and Improved Vaccines

In November 2023, the Food and Drug Administration (FDA) approved the first vaccine for Chikungunya virus, bringing the total number of vaccine-preventable infections to thirty-two.2,3 Two approved vaccines are now available for Chikungunya virus: IXCHIQ, a live attenuated vaccine, and Vimkunya, a virus-like particle vaccine. Both vaccines are intended for patients traveling to areas where active Chikungunya cases are reported. The Vimkunya vaccine can be given to patients ages 12 and older, while the IXCHIQ vaccine is approved for patients 18 to 60 years old. Use of IXCHIQ has been restricted for patients older than 60 following five reports of hospitalizations for cardiac and neurologic events after vaccination.4 Further investigation is ongoing.

Earlier that same year, in May 2023, the FDA approved vaccines for Respiratory Syncytial Virus (RSV).5 Three RSV vaccines—Arexvy, mRESVIA, and Abrysvo—are approved for patients aged 60 and older. Patients ages 50 and older who are at higher risk for severe RSV infection and hospitalization are also eligible for vaccination.5 In addition to older adults, the Abrysov vaccine has been approved for use during pregnancy. Pregnant patients between 32 and 36 weeks gestation during RSV season (September to January) are

eligible for vaccination.6 Antibodies pass through the placenta to provide protection to the child during their first RSV season. Currently, repeat RSV vaccination during subsequent pregnancies is not recommended.

The most recent pneumococcal vaccine recommendations have lowered the age range for vaccination from 65 to 50 years and older. Patients aged 19 to 49 who are immunocompromised or have chronic medical conditions are also eligible for vaccination.[7] While the multiple pneumococcal vaccines allow for enhanced protection against pneumonia, they complicate decisions about who needs which vaccine and when. Figure 1 provides an algorithm to help navigate pneumococcal vaccine decision-making based on age, medical conditions, and previous vaccination status.

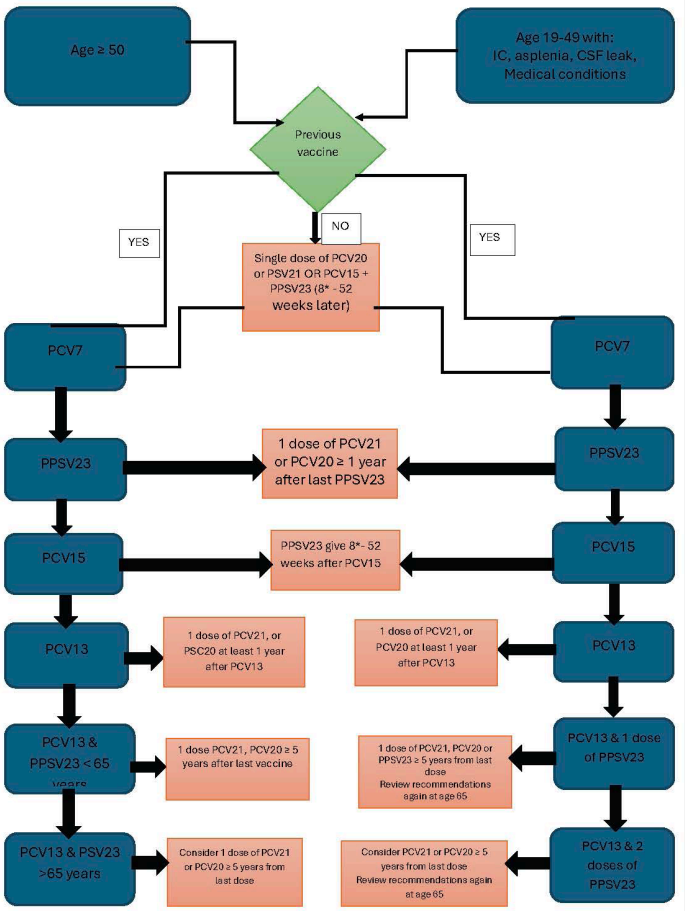

Figure 1. Pneumococcal Vaccine Recommendations.7
Medical conditions = Diabetes mellitus, chronic disease of the lung, heart and liver, cochlear implant, tobacco use, alcohol use disorder; PPSV = pneumococcal polysaccharide vaccine; PCV = pneumococcal conjugate vaccine

New Vaccine Technology

The recent SARS-CoV-2 pandemic reminded the world of the devastation an infection can cause. However, it also demonstrated the ingenuity of the scientific community and led to the development of mRNA COVID-19 vaccines. The COVID-19 vaccines were developed in less than one year but built upon three decades of research into nanotechnology.[1] The Pfizer-BioNTech COVID-19 vaccine and the Moderna COVID-19 vaccine received Emergency Use Authorization (EUA) from the Food and Drug Administration (FDA) in December 2020.[8] These vaccines, along with other treatment options, helped turn the tide in the fight against SARS-CoV-2.

The mRNA vaccine technology has brought the future of vaccine development into the present. The versatility, rapid and targeted development capabilities, and expedited production make mRNA nanotechnology an attractive platform for new vaccine creation.[8] Clinical trials are currently underway for mRNA vaccines to prevent other infections, including influenza and avian influenza, Zika, cytomegalovirus (CMV), and rabies.[9],[10] Personalized cancer vaccines using mRNA platforms for pancreatic cancer, melanoma, and non-small cell lung cancer are also in development.9,10,11

Importance of Routine Vaccination

Unfortunately, sometimes what's old becomes new again. Since 2000, measles has been considered an infection of the past, as it was declared eliminated in the United States of America. Since that time, rates of vaccination for Measles, Mumps, and Rubella (MMR) have declined nationwide. Several regions of the country have MMR vaccination rates below 95%, the goal threshold to provide herd immunity. Consequently, a measles outbreak marked the beginning of the year 2025. As of May 29, 2025, there are 1,088 confirmed measles cases in 33 different states and three reported deaths.12 The largest outbreak originated in west Texas, with 742 confirmed cases.13 All three reported deaths have come from the Texas outbreak.

The most effective method to protect against measles infection is to stay current on vaccination. The MMR vaccine is 93% effective after one dose, and

97% effective after two doses.14 Adults born prior to 1957 are presumed to have immunity from measles infection and do not need an MMR booster. Adults who received their routine childhood immunizations are also presumed immune and do not need a booster, with a few exceptions. Adults born between 1963 and 1967 received the inactivated MMR vaccine instead of the more effective live virus MMR vaccine and may benefit from a booster with the current MMR vaccine.14 Persons born prior to 1989 likely only received one dose of MMR and may also benefit from a booster.14 Measles antibody titers can be measured to check immunity status, and an MMR booster administered if they are undetectable. However, if a patient requests an MMR booster, there is minimal risk in administering the vaccine to immunocompetent adults.

While pertussis has not garnered much media attention compared to the current measles outbreak, cases are also on the rise. In 2024, there were 35,435 cases of pertussis reported—a six-fold increase from cases reported in 2023.15 Pertussis cases in 2024 were double the average number of cases in the pre-COVID-19 pandemic era.15This uptick in cases has continued into 2025. Again, the best defense against pertussis is through vaccination. Tetanus and diphtheria vaccines are recommended every ten years, with the inclusion of acellular pertussis (Tdap) recommended at least once in adulthood.16 A Tdap booster is also recommended with each pregnancy to protect the infant.16 It is prudent for parents, grandparents, and anyone else often surrounding an infant to receive a Tdap booster. Infants and young children are at greatest risk of severe pertussis disease and even death.

Vaccine Benefits Beyond Infection Prevention

Vaccine benefits can extend beyond the infection they were designed to prevent. Recent data has demonstrated that the Neisseria meningitidis, or meningococcal serotype B vaccine, specifically the MenB-4C (Bexsero) vaccine, provides protection against gonorrhea in addition to meningitis.17 In fact, the United Kingdom now includes the MenB-4C as part of their routine childhood immunization recommendations. MenB-4C can be given in addition to the Meningococcal serotypes ACWY vaccine.

Additionally, shingles vaccination has demonstrated protection against cardiovascular disease and dementia in addition to providing protection against shingles. The current vaccine for herpes zoster, Shingrix, is approved for adults aged 50 years and older. Shingrix is 96.6% effective at preventing shingles and 91.2% effective at preventing post-herpetic neuralgia.18 Research has demonstrated a 1.9-fold higher risk of stroke within the first 30 days following a shingles outbreak.19 The increased risk of stroke declines over time but persists up to one year. Activation of prothrombotic HZ-exosomes by the herpes zoster virus was identified as the cause for the increased stroke risk.20 The HZ-exosomes activate platelets and promote formation of platelet-leukocyte aggregates. The prothrombotic effects can be mitigated by aspirin therapy.20 The increased risk of stroke can be avoided altogether by vaccination. Another study, published this April, demonstrated a 20% decrease in the rate of dementia for patients who received the shingles vaccine compared to those who were not vaccinated.21 Risk reduction for dementia and stroke is a promising additional benefit of vaccination. Further research into the link between herpes zoster and dementia could lead to a better understanding of the pathophysiology of dementia and new treatment options for this devastating disease.

While public opposition to vaccination has increased over the years, vaccines remain an important tool in the fight against infectious disease. Vaccines against new pathogens such as malaria and human immunodeficiency virus (HIV) are in development. The new mRNA vaccine technology has opened the door to rapid development of new vaccines. Beyond infectious disease, vaccines are being explored as treatment options for cancer. The human papillomavirus vaccine (HPV) has already demonstrated the success of this approach. Rates of cervical cancer have dramatically decreased since HPV's addition to the routine immunization schedule. Hopefully, vaccine research will continue to push forward to improve the health of the global community.

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Retirement Among Physicians

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Dr. Ted Higgins, a vascular surgeon, has dedicated his career to expanding surgical access in Haiti and the Dominican Republic. Inspired by early mission experiences, he founded the Higgins Brothers Surgicenter for Hope in 2016, honoring his family's medical legacy. His work continues to transform healthcare, train local surgeons, and bring hope to underserved communities.

When discussing retirement among physicians, there is generally a wide range of emotions that ensues: anticipation, anxiety, fright, pleasure, and despair, the list goes on. It is a time when hobbies can resume, the "honey do" list is accomplished, golf handicaps are lowered, and travel plans initiated. For many this is enough, it is a time to reflect and enjoy the sunset years of a well-earned retirement life.

There are other retiring physicians though who need help to fill the personal void left from interactions with patients and medical personnel. We never stop becoming the person we are. Retirement for many requires a connection that satisfies the need to assist others. To those aspiring retiring medical providers, I would suggest an often-maligned word in our field...volunteer.

There are wonderful community opportunities to help in soup kitchens, clothes closets, museum docents, day care centers, and many other community volunteer activities to help others. The challenge is no longer about building a medical practice, raising and providing for your family, or even about your personal accomplishments, income, or reputation. It's now about the causes that help the well-being of others. David Brooks, the noted NY Times columnist and Yale professor talks about the quest for a moral life in his book, "The Second Mountain." While the first mountain is the progression we each follow in developing our careers, goals, and families, the second mountain is about societal causes that benefit others. No longer is our ego a factor, it's about helping others, and providing an opportunity.

One of the best examples of community service I'm familiar with is participation in national and international medical mission trips. It amazes me that, so few Americans understand the lack of medical care in third world countries. We take for granted our access to medical care that includes nurses, doctors, urgent care, and emergency departments. In much of the world traveling 1- 2 days to seek medical attention is the norm. Care may not be provided

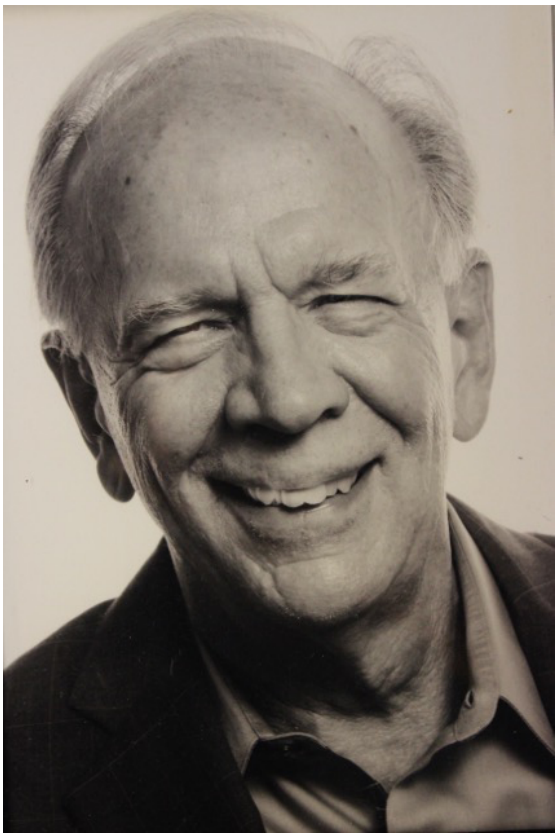
even then until payment is received. There is no IMTALA law in 3rd world countries requiring emergency care be provided by medical facilities.

> *For many this is enough, it is a time to reflect and enjoy the sunset years of a well-earned retirement life.*

This type of mission experience whether in an inner city, Indian reservation, or 3rd world country changes the lives of people, not the patients as much as the medical providers. The gratitude they receive from patients is genuine. It reorients priorities and broadens the horizons of those medical providers who experience these situations. It is an experience for all ages as everyone benefits.

So when considering retirement there are many local community locations and international opportunities that would benefit greatly from the experience and knowledge of a retired physician. It doesn't even need to be in the medical field. In this world of AI and computers, the human component is still the most important factor in providing medical care.

"The Doctor" A 19th Century Painting Still Applies Today



By Keith Jantz, MD

The origin of Sir Luke Fildes' painting entitled “The Doctor”, completed in 1891, remains a matter of controversy. Some art historians believe the painter created his deference to his son, who died of typhoid fever at age one. Others contend that Fildes was commissioned to paint the scene as homage to Queen Victoria, who also lost a son during her reign over England. Reports suggest Henry Tate commissioned Fildes to create a work of "social realism," though the painting's Victorian setting does not accurately reflect the medical expertise available in late 19th-century England—notably absent are the instruments familiar to physicians of that era. The true inspiration behind Fildes' tribute to the physician and medical empathy may never be fully known.

Yet the artwork's celebration of physicians and their compassionate care for the suffering continues to resonate across generations, symbolizing the dignity and altruism inherent in the medical profession. As spoken by surgeon W. Mitchell Banks: "What do we not owe to Mr. Fildes for showing to the world the typical doctor as we would all like him to be shown – an honest man and a gentle man, doing his best to relieve suffering?" In 1947, the US Postal Service issued a stamp commemorating the 100th anniversary of the American Medical Association, depicting Sir Fildes' painting of The Doctor. His iconic painting continues to reside in the Tate Modern Gallery in London.

Although Sir Luke Fildes painted "The Doctor" in the 19th century, its profound messages about human nature in medicine remain strikingly relevant in today's 21st-century healthcare landscape. Despite substantial technological advances that have transformed diagnostic capabilities and treatment options, the fundamental depiction of interactions between physician, patient, and family remain unchanged from 130 years ago. Fildes' masterwork captures these emotions and the complexities of medical encounters with such eloquence that they continue to reflect contemporary healthcare realities in our advanced Western society. Examining individual elements of the painting reveals remarkable parallels between 19th-century medical dilemmas and the challenges facing today's physicians.

At the painting's center lies the primary figure of any medical encounter: the patient—a helpless, critically ill little girl. The girl appears listless, her left arm trailing from the pillows, completely vulnerable to whatever ailment has overcome her. Such appearance symbolizes the helplessness that patients present to their medical provider as they present troubling symptoms that raise concerns about serious or potentially fatal diseases. Uncertainty creeps into the mind, generating fear that the worst may be imminent, while patients simultaneously hope for clarity from their medical provider. Today, patients may be armed with information from the media, the internet, family members, or well-meaning relatives pushing for self-diagnosis. However, even with that partial reassurance of knowing what's going on, doubt inevitably evolves into fear or even helplessness, compelling patients to open up and seek professional assistance for their illness.

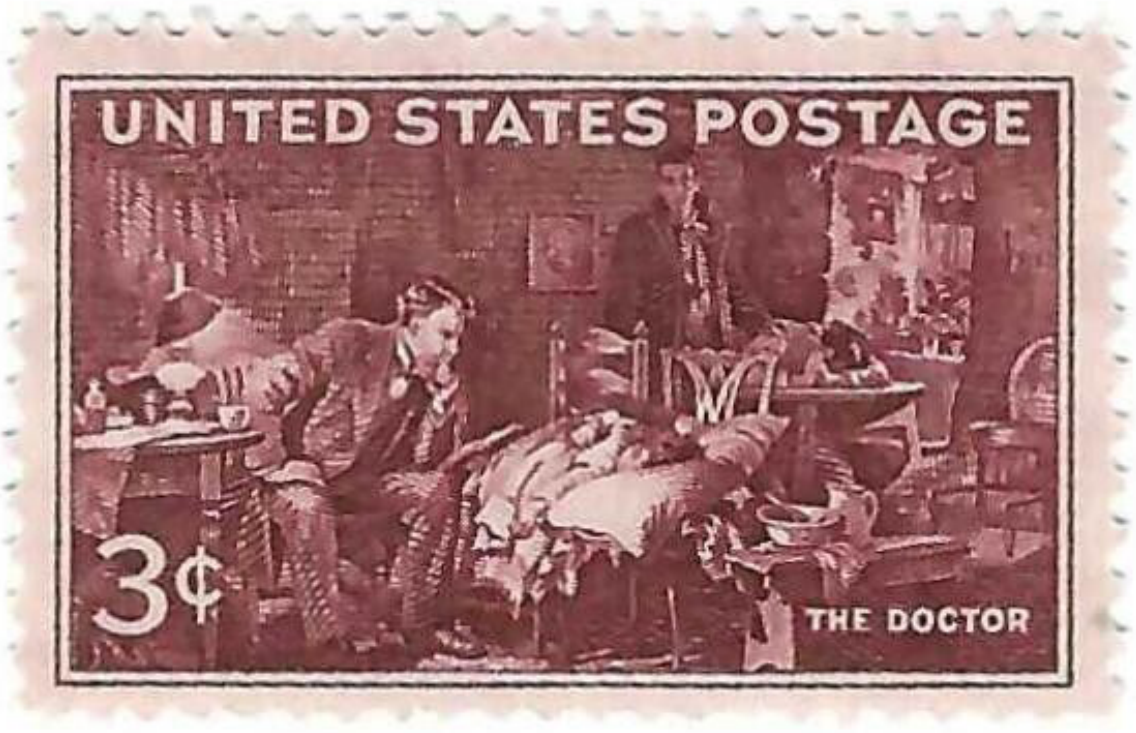
To the painting's right sits a grieving mother, face buried in her hands at the table, hands clasped in fear or prayer, while the father offers a comforting hand on her shoulder. Though the viewer cannot know whether the child will survive, the mother has already assumed the worst possible outcome. She embodies the ultimate worrier, the perpetual pessimist, the "glass half empty" person now pushed to unprecedented emotional distress by her beloved daughter's illness. Any contemporary primary care physician treating seriously ill patients recognizes this archetype of the distraught relative. Emotions run high during severe medical encounters, and stressful situations sometimes bring out the worst in people.

Standing in the background, the father fixes his gaze directly on the doctor with a demanding, almost threatening expression while simultaneously comforting his wife. His facial expression implies the

"The Doctor" A 19th Century Painting Still Applies Today

doctor must save his daughter, or anger will ensue. He justifies this stance by relying on the doctor's wisdom and medical expertise to provide answers beyond a layman's capability. Today's physicians constantly face similar demands from patients and families to produce positive results, even when the odds are insurmountable, and the prognoses are particularly grim. Family anger generated by poor outcomes from severe or terminal illnesses can manifest in threats, financial disputes, and legal challenges through malpractice lawsuits. While attempting to support his wife emotionally, the father maintains the stoic paternal behavior characteristic of demanding a positive outcome.

The painting's setting tells its own compelling story while remaining applicable to contemporary societal challenges. The family inhabits a home of limited resources, characterized by poverty. Their precious daughter must endure her illness on a makeshift bed of pillows and chairs. Scattered laundry and dishes suggest a less-than-sanitary environment for managing a medical crisis. The minimal illumination from a single tilted lampshade—while creating beautiful artistic effect—severely limits the physician's ability to examine the patient properly. This scene epitomizes the resource limitations that impoverished people navigate today, constraints that hamper physicians' ability to diagnose and treat effectively, ultimately resulting in



poorer outcomes. Numerous contemporary studies confirm the association between low income and higher mortality rates, validating what Fildes observed over a century ago.

At the center of the scene stands the physician, deep in thought, his attention focused solely on the patient, seemingly oblivious to the drama unfolding around him. His puzzled, contemplative posture reveals that despite his medical expertise and years of training, his diagnostic acumen has failed him, yielding no precise diagnosis or effective treatment plan. The patient's disease is prevailing, and he remains constrained by ineffective medical resources—evidenced by a single bottle of medicine, a cup, and a spoon.

Similarly, today's physicians frequently experience personal frustration when confronting the progression of a disease despite inadequate medical resources. Technological advances aside, contemporary medicine continues to suffer from limitations in delivering optimal treatments to the most vulnerable patients.. Medication shortages, restricted access to diagnostic equipment, government regulations, excessive documentation requirements, and insurance company interference in medical decision-making are all symbolized by that small lamp providing meager light for examining the critically ill child and the solitary elixir representing available therapy. When combined with the intense emotional atmosphere created by the parents, one begins to appreciate the immense stress on the physician while marveling at his ability to remain intently focused on the distressed child.

> *...today's physicians frequently expereince personal frustration when confronting the progression of a disease despite inadequate medical resources.*

All these elements converge dramatically in Sir Luke Fildes' portrayal of the doctor's plight in the 19th century. Unfortunately, despite 160 years of technological advancement, pharmacological breakthroughs, healthcare system organization, and governmental and corporate efforts to support medical needs, fundamental aspects of the physician-patient encounter remain unchanged from the era of the horse-and-buggy doctor.

Added comment:
Dr. Richard Free
JULY 4, 2019

The practice of medicine itself serves as a metaphor for adaptation to perpetually incomplete information—accepting, defining, and ranking probabilities while moving forward despite risk and suffering, both for ourselves and our patients. We strive always to make the best calculated decisions based on available evidence, understanding that while we may not always make the objectively "right" choice, we must always make the right choice in real time with the information available to us.

Music and Medicine

Author

Brad Garstang MD

Music and Medicine Family Physician

Dr. Brad Garstang is a family physician in Liberty, Missouri. He has practiced medicine for 23 years and is the President-elect of the Kansas City Medical Society.

"I love science, and it pains me to think that so many are terrified of the subject or feel that choosing science means you cannot also choose compassion, or the arts, or be awed by nature. Science is not meant to cure us of mystery, but to reinvent and reinvigorate it."

-Robert Sapolsky

As a family physician in Kansas City for the last 23 years, I have both seen and heard the benefits of music on my patients, friends, family and myself. When I applied to medical school at UMKC in 1993, I didn't realize that there was also a Conservatory of Music at UMKC. Once accepted, I auditioned to play the bassoon at the conservatory, initially to earn scholarship money and to manage stress from medical school. Little did I know that I would also meet my future wife, a flutist in my woodwind quintet. This set the stage not only for a career in medicine but also laid the foundation for a life following a passion for music.

Currently in a new empty-nest stage of life, my wife and I play in our community orchestra and with our "La Gioia" woodwind quintet. I was also fortunate to recently perform in a Kansas City Symphony ProAm concert which paired professional symphony musicians with community amateurs like myself.

The Kansas City Medical Society has increasingly focused on improving our community's physician wellness in recent years. Music has helped me prevent burn-out and build new friendships. Aside from exercise, I can't think of another activity that makes us so resilient to burnout.

In my experience, music can be an incredible outlet for patients to express themselves, release stress, and form community through making music with others. It wields the power to help us worship our creator on Sundays, hype up sports teams and fans before competition, remember loved ones at funerals, motivate us during exercise, and help us decompress while driving home from the office.

"Music is unique among the arts, as it is both completely abstract and profoundly emotional. It has no power to represent anything external but has a unique power to express inner states or feelings. Music can pierce the heart directly." -Oliver Sachs

Learning to appreciate many forms of music is helpful, although the music we grew up with in our teenage years seems to be what we most connect with. In Oliver Sacks' book 'Awakenings', and later in a film with Robin Williams and Robert De Niro, patients with dementia retrieve cognitive function when music from their youth is played. Music also has the power to heal. Music therapy is used for cases of aphasia, Tourette's syndrome, and Parkinson's, for instance. In Oliver Sacks' 2007 book, 'Musicophilia', he examines the powers of music through the individual experiences of patients, musicians, and everyday people.

My hope is that we continue to understand the importance of music in our communities, teach it to our children, support local musicians, and recognize its connection to our patients' physical health. I would also encourage all physicians to attend live music concerts, learn an instrument, or sing with others.

"If I were not a physicist, I would probably be a musician. I often think in music. I live my daydreams in music. I see my life in terms of music." -Albert Einstein

KCMS AWARDS

2025 Award Recipients

KCMS AWARDS
2025 Award Recipients

Thanks for all who joined us in November to celebrate our accomplishments from 2025! We had a wonderful time at Grand Street Cafe and enjoyed celebrating our award winners together. The Kansas City Medical Society presented the following 2025 Awards at our Annual Meeting.

Patient & Community Advocate Award

Patrick Christopher, MD and Robert Weiss, MD

Drs. Patrick Christopher and Robert Weiss are oral and maxillofacial surgeons specializing in cleft lip and palate repair in Kansas City and abroad. In a relatively short time, they have built strong partnerships across Kansas City's hospital systems and co-founded Forever Smiles, a nonprofit dedicated to making comprehensive cleft care accessible for families locally and internationally.

Rising Star

Ashley Holly, MD

Recognizes a physician who has made significant contributions to medicine in the Kansas City Metro Area early in their career.

Dr. Ashley Holly is a highly regarded general surgeon known for combining excellent technical skill with a compassionate, patient-centered approach. Colleagues and patients alike value her clear communication, meticulous preparation, and calm leadership in the clinic and operating room.

She chairs the OR Subcommittee and serves on the Medical Executive Committee, leading initiatives that strengthen safety, efficiency, and quality while mentoring peers. At 39, Dr. Holly has already distinguished herself and is well positioned to be a major leader at NKC Health.

Exemplary Leadership Award

Carl Myers, MD

Dr. Myers is a family medicine physician in Platte City, Missouri—the community where he was raised. Deeply engaged at both the local and state levels, he has served on the Missouri State Board of Healing Arts and is recognized for his leadership and service to the profession.

He recently received a special Dean's Distinguished Service Award from the University of Missouri School of Medicine for his efforts to raise scholarship funds for medical students. Dr. Myers upholds the highest standards of patient care and community stewardship.

Exemplary Leadership Award

Rebecca Lowry, MD

Dr. Rebecca "Becky" Lowry is Medical Director of The University of Kansas Cancer Center Survivorship Transition Clinic. As Chief Wellness Officer, she led systemwide initiatives before and during COVID-19 and founded the Office of Professional Well-Being, which provides physicians confidential, no-cost access to certified mental-health specialists in person or virtually. A recognized advocate for clinician well-being and suicide prevention, she now serves as Associate Chief Medical Officer for UKHS and received the University of Kansas Medical Center's Early Career Achievement in Medicine Alumna Award (2020).

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