



## Alcohol use during pregnancy

- In a survey conducted between 2011- 2013 approximately:
  - 1 in 10 pregnant women in the United States reported drinking alcohol in the past 30 days
  - 1 in 33 pregnant women report binge drinking (having 4 or more drinks at one time) in the past 30 days

– Green PP, McKnight-Edy LR, Tan CH, Meila B, Denny CH. Vital signs: alcohol exposed pregnancies—United States, 2011–2013. *MMWR Morb Mortal Wkly Rep*. 2016;65(4):31–37

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## Alcohol use during pregnancy in Australia

- During pregnancy, 50% to 59% of the women surveyed reported consuming alcohol at some time during pregnancy
- Only 41% of women abstaining in all three trimesters
- The majority of women will either abstain from alcohol or will cut down the quantity of alcohol they consume following pregnancy awareness, 36% report drinking alcohol during late pregnancy

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## Prenatal alcohol exposure (PAE)

- Research over the past 50 years has clarified the harmful effects of alcohol on the developing fetus and subsequent **lifelong** physical, behavioral and learning disabilities

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## Safe alcohol use during pregnancy

- There is no amount of alcohol known to be safe to drink during pregnancy
- All drinks that contain alcohol have the potential to harm a developing fetus

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## Safe alcohol use during pregnancy

- While not all children who have prenatal alcohol exposure develop a Fetal Alcohol Spectrum Disorder
- Currently, it is not possible to predict which fetus will be affected
- The safest choice is for women to refrain completely from alcohol while pregnant or trying to get pregnant

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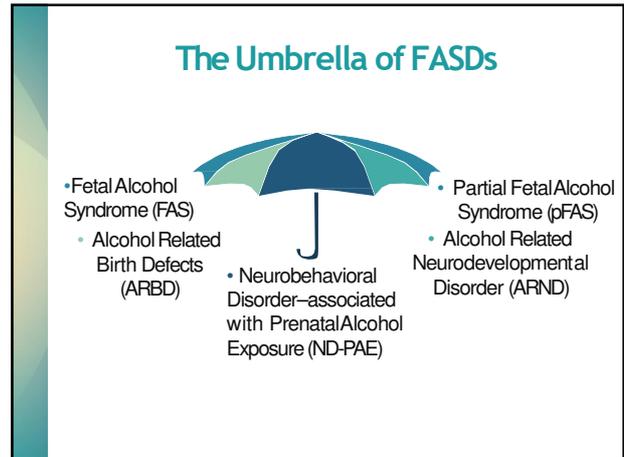
## No safe alcohol use during pregnancy

- There is **no amount** of alcohol during pregnancy that is risk-free
- There is **no kind** of alcohol during pregnancy that is risk-free
- There is **no time** during pregnancy when alcohol consumption is risk-free

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## Fetal Alcohol Spectrum Disorders (FASDs)

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### Diagnoses Resulting From In Utero Exposure to Alcohol

**ARBD**

- Congenital anomalies only
- Rare
- Smallest tip of iceberg

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### Diagnoses Resulting From In Utero Exposure to Alcohol

**FAS & pFAS**

- Facial features, CNS dysfunction/anomalies, possible growth deficits
- Small proportion of patients with a FASD

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### Diagnoses Resulting From In Utero Exposure to Alcohol

**ARND**

- Neurodevelopmental/behavioral effects without cardinal dysmorphic features
- Common
- Portion of iceberg underwater

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### Diagnoses Resulting From in Utero Exposure to Alcohol

**ND-PAE**

- Neurobehavioral features but not physical features
- Common, missed and misdiagnosed
- Portion of iceberg underwater

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### Prenatal Alcohol Exposure: Relevance to Practice

- Most common *preventable* cause of intellectual disability and behavior disorders
- Lifelong effects
- More serious effects than other drugs or teratogens

“Of all the substances of abuse, including cocaine, heroin, and marijuana, alcohol produces by far the most serious neurobehavioral effects in the fetus.”  
 - Institute of Medicine, 1996

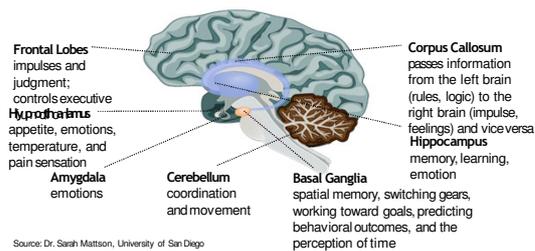
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### When to Consider a FASD Diagnosis?

- Developmental, cognitive, or behavioral concerns
- Complex medical concerns (e.g. cardiac)
- Growth deficits
- History of maternal alcohol or drug use
- Asibling diagnosed with a FASD
- Dysmorphic physical features consistent with FASD are present

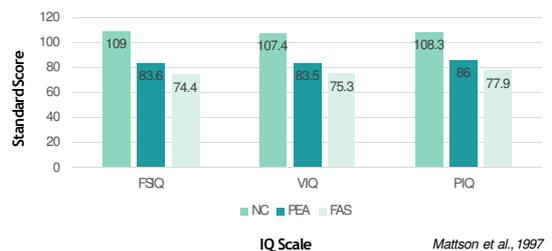
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### Areas of the Brain Affected By Prenatal Alcohol Exposure



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### General Intellectual Performance



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### FASD: Relevance to Pediatric Practice High Prevalence

- Prevalence in a Midwestern city (May, et al 2018)
  - FAS: 0-7.8/1000 children (0% to 0.8% 1<sup>st</sup> graders)
    - Accounts for 20% or less of all FASDs
- FASDs: 11.3-50/1000 children (1 to 5% 1<sup>st</sup> graders)
- Increased prevalence among children in child welfare (Lange, 2013)
  - FAS: 60/1000 children (6%)
  - All FASD: 169/1000 children (16.9%)

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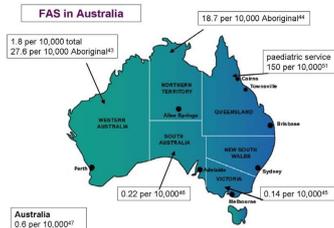
### FASD: Perspectives on Prevalence

Birth Defect	Prevalence
Down syndrome	1.2/1000 births
Cleft lip +/- palate	1.2/1000 births
Spina bifida	1/1000 births
Autism	12.5-14/1000*
Fetal Alcohol Syndrome (FAS)	6-9/1000*
All FASDs	24-48/1000* (May, 2014)

\*per 1000 school age children

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## FAS in Australia



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## Potential Benefits of a Diagnosis

- Parental relief
- Access to evidence-based interventions
- Avoids unnecessary testing, referrals, and interventions
- Reduce recurrence

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## Why Pediatricians Do Not Routinely Screen for FASD

- Insufficient training
- Discomfort in making the diagnosis
- Stigma

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## Assessment Domains for Diagnosis

- History of Prenatal Alcohol Exposure
- CNS (structural, neurologic, functional)
- Growth
- Dysmorphic Facial Features

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## Obtaining History Prenatal Alcohol Exposure as Routine Care

- Part of all well child assessments
- As part of addressing parent concerns
- Review family, social and pregnancy histories
- Review all potential exposures
- Explain that alcohol is commonly consumed, often before pregnancy is recognized

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## Obtaining Prenatal Alcohol Exposure History as Routine Care

- Use open-ended questions  
**EXAMPLE:** "Tell me about your alcohol use in the 3 months prior to finding out you were pregnant."  
**NOT:** "You didn't drink while pregnant, did you?"
- Ask about partner's drinking habits
- Provide assurance that to provide the best care possible it's important to know all of the facts about the pregnancy

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## Record Review & History

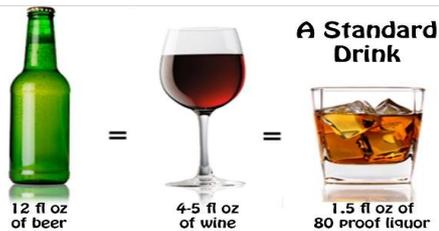
- Prenatal Alcohol Exposure History
- Birth records (weight, length, head circumference)
- Medical history/records (birth defects?, exposures?)
- Postnatal growth records
- Developmental/behavioral history
- Psychological testing, including cognitive and behavioral assessments

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## AAP's Screening for Prenatal Alcohol Exposure:

- Screening for prenatal alcohol exposure can be
- incorporated into a standard script to help ease potential pediatrician discomfort
  - provide reassurance to the caregiver when discussing topics that may be sensitive
  - done during birth history, anticipatory guidance, or any other appropriate portion of the parent interview, after asking standard guidance questions (e.g., about medications, tobacco, home environment), one can ask about prenatal alcohol exposure.

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## AAP's Screening for Prenatal Alcohol Exposure:

*AAP's Screening for Prenatal Alcohol Exposure: An Implementation Guide for Pediatric Primary Care Providers* provides some sample screening questions:

- How far along were you before you found out you were pregnant?
- Before you knew you were pregnant, how much alcohol (beer, wine, or liquor) did you drink?
- After you found out you were pregnant, how much alcohol did you drink?

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## How to screen

- Ask open-ended questions (that cannot be answered yes or no)
  - "How much alcohol were you drinking before you knew you were pregnant? (NOT "Did you drink alcohol before you knew you were pregnant?")
- Be attuned to body language or hesitation in the response
- Follow up on non-specific responses

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## AAP's Screening for Prenatal Alcohol Exposure:

If a positive response is obtained, additional questions about amount, frequency and timing may be appropriate for diagnostic purposes.

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## What happen after screening

- Document the results of the positive or negative screening

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## Remember

- Any acknowledgement of alcohol consumption during pregnancy counts as a positive screen for PAE
- A positive screen does not equate to an FASD diagnosis

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## AAP Bright Futures

Suggested contact points:

- All prenatal visits
- The earliest well child visits
- All new patient visits
- Whenever a related concern is observed or raised



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## Conversations with Mothers: Practice Compassion (NOFAS.org)

- Be gentle, ask questions, and listen
- Stick to the facts
- Be non-judgmental, avoid stigmatizing language
- Remind her that you care about her, her child, and their family
- Use person first language, e.g. “child with a FASD”

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## Best Definition of Cognition and Behavior in FASD: ND-PAE

- DSM-5 emerging diagnosis
- Criteria describes impairment in *neurocognition, self-regulation and adaptive function*
- Diagnosis is made in the context of confirmed prenatal alcohol exposure
- Criteria do not require the presence of physical features

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## Neurobehavioral Effects

### Neurocognitive deficits

- Low IQ or developmental delay
- Executive functioning deficits
- Impaired learning, memory or specific learning problems (esp. visual-spatial and math)
- Motor functioning delays for younger children



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## Neurobehavioral Effects

### Self-regulation problems

- Self-soothing, sleep
- Difficulty managing mood
- Behavior management issues
- Attention problems (esp. shifting attention)
- Poor impulse control



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## Neurobehavioral Effects

### Difficulty learning/Delayed adaptive skills

- Communication deficits, especially social communications such as understanding idioms or jokes
- Problems with social skills
- Problems with self care or daily living skills
- Motor issues in younger children

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## Physical Effects

- Weight and/or length growth deficiency (pre or post natal)
- Abnormal brain structures (esp. small cranium, corpus callosum)
- Dysmorphic facial features:
  - Short palpebral fissures
  - Smooth philtrum
  - Thin vermilion border

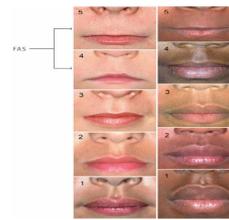
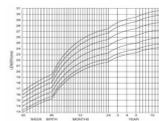


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## Palpebral Fissure & Lip/Philtrum



Palpebral fissure length endocanthion to exocanthion



Lip-Philtrum Guides 1 & 2

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## FASD Diagnostic Schema Available

### Currently available guidelines:

- Updated Clinical Guidelines for Diagnosing Fetal Alcohol Spectrum Disorders (Hoyme et al, *Pediatrics*, 2016)
- Canadian guidelines for diagnosis (Cook et al, *CMAJ*, 2015)
- National Task Force on FAS and FAE (2004)
- FASD 4-digit diagnostic code (Astley and Clarran, *Alcohol*, 2000)

### Historically available guidelines:

- A practical clinical approach to diagnosis of fetal alcohol spectrum disorders: clarification of the 1996 Institute of Medicine criteria (Hoyme et al, *Pediatrics*, 2005)
- Fetal alcohol spectrum disorder: Canadian guidelines for diagnosis (Chudley et al, *CMAJ*) 2005
- Fetal Alcohol Syndrome (The Lancet, 1973)

The Diagnostic and Statistical Manual version 5 published by the American Psychiatric Association also proposes criteria for neurobehavioral disorder associated with prenatal alcohol exposure.

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## Pathway to a Diagnosis

- The AAP FASD Toolkit: [aap.org/fasd](http://aap.org/fasd)
- Comprehensive, one-stop resource



### Toolkit

The Fetal Alcohol Spectrum Disorders (FASD) Toolkit was developed to raise awareness, promote surveillance and screening, and ensure that all affected children receive appropriate and timely interventions.



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## Potential Differential & Comorbid Diagnoses

### Behavioral disorders examples

- ADHD
- Intellectual disability
- Early trauma
- Conduct disorder/oppositional defiant disorder
- Dysfunctional parenting

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## Potential Differential & Comorbid Diagnoses

### Genetic and growth disorders examples

- Williams syndrome (1 in 10,000-20,000 births US)
- Dubowitz syndrome (<200 cases worldwide)
- Fetal valproate syndrome (prevalence unknown)
- Maternal PKU fetal effects (1 in 10,000-15,000 births US)
- Nutritional insufficiency–growth
- Prenatal smoking–growth

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## Delivering the Diagnosis

- Show compassion
- Use active listening
- Be sensitive to the possibility of stigma
- Discuss treatment options, better parent-child interactions

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## Diagnosis Established *What now?*

- Natural history
- Future planning
- Working with school
- Medical home
- Develop team
- FASDs may not respond to usual treatments
- AAP toolkit: [www.aap.org/fasd](http://www.aap.org/fasd)

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## Referrals

For diagnosis, depending on available resources:

- FASD diagnostic clinic
- Genetics and dysmorphology clinic
- Neurodevelopmental/behavioral pediatrician
- Neuropsychologist or behavioral psychologists for ND-PAE or ARND

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## Referrals

For treatment/care needs and care planning or management:

- Neuropsychologist, clinical psychologist, school psychologist, early intervention
- SLP, OT, or PT as indicated
- Social work
- Medical specialists as indicated

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## Neonatal Abstinence Syndrome (NAS)

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### Substance use by pregnant women

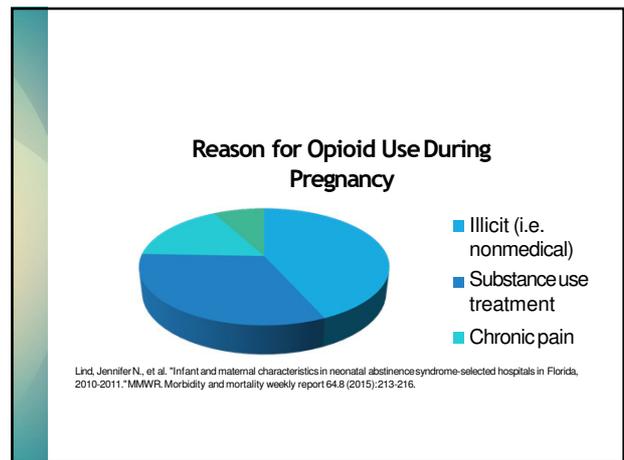
- Current illegal drug use among pregnant women remains relatively stable
  - 2007-2008 (5.1%)
  - 2009-2010 (4.4%)

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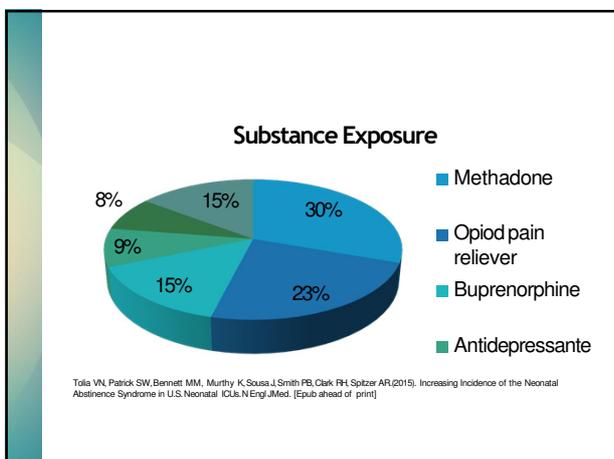
### Comparison of Substance Use Among Women 15 to 44 Years of Age by Pregnancy Status: 2009-2010

	Pregnant Women, %	Non-pregnant Women, %
Illicit drug use	4.4	10.9
Alcohol use	10.8	54.7
Binge drinking	3.7	26.4
Cigarette use	16.3	26.7

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### Neonatal Abstinence Syndrome

- A group of symptoms that some newborns exhibit if their mother has taken opioids (addictive prescription or illicit use)
- Among neonates exposed to opioids in utero, withdrawal signs will develop in 55-94%
- Which exposed neonates develop NAS are hard to determine

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### NAS symptoms

Three organ systems primarily involved:

- Central nervous system
- Autonomic over reactivity affecting:
  - Metabolism
  - Vasomotor system
  - Respiratory system
- Gastrointestinal system

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### NAS symptoms

- Central nervous system disturbances
  - Difficulty being consoled
  - Hypertonia
  - Tremulousness
  - Exaggerated Moro reflex
  - High-pitched cry
  - Myoclonic jerks
  - Seizures

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### NAS symptoms

- Metabolic/ vasomotor/ respiratory disturbances
  - Diaphoresis (sweating)
  - Fever
  - Frequent yawning and sneezing
  - Nasal stuffiness
  - Mottling
  - Tachypnea

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### NAS symptoms

- Gastrointestinal disturbances
  - Poor feeding
  - Excessive sucking
  - Uncoordinated sucking
  - Poor weight gain
  - Vomiting
  - Diarrhea
  - Dehydration

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### NAS symptoms

- Usually begin 24 to 72 hours after birth depending on what the infant was exposed
- For some infants withdrawal may be delayed until 5-7 days or later after birth

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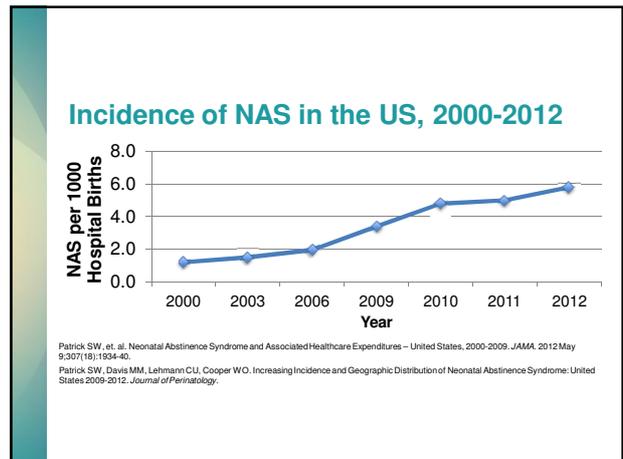
### Narcotic drugs that may cause NAS in a newborn

- |                                 |                                     |
|---------------------------------|-------------------------------------|
| • Heroin                        | • Demerol (Meperidine)              |
| • Methadone                     | • Fentanyl patch                    |
| • MS-Contin (Morphine)          | • Dilaudid (Hydromorphone)          |
| • OxyContin (Oxycodone)         | • Suboxone (Buprenorphine/naloxone) |
| • Percocet/Percodan (Oxycodone) |                                     |
| • Vicodin (Hydromorphone)       |                                     |

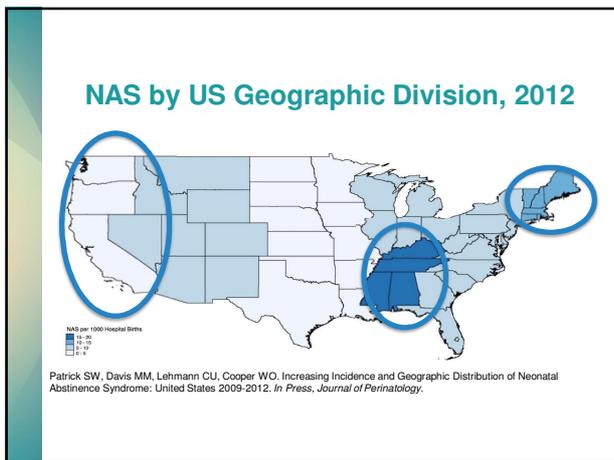
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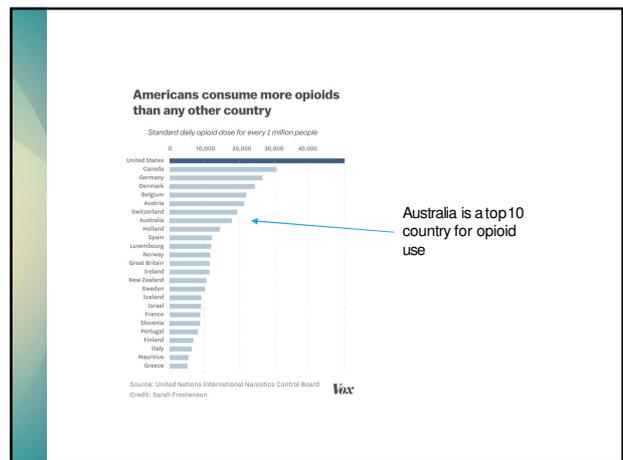
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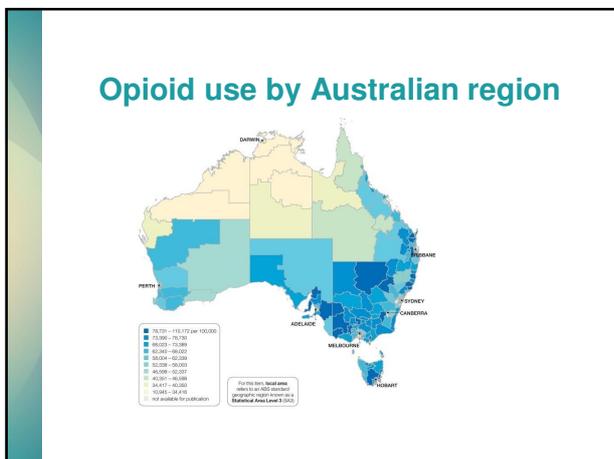
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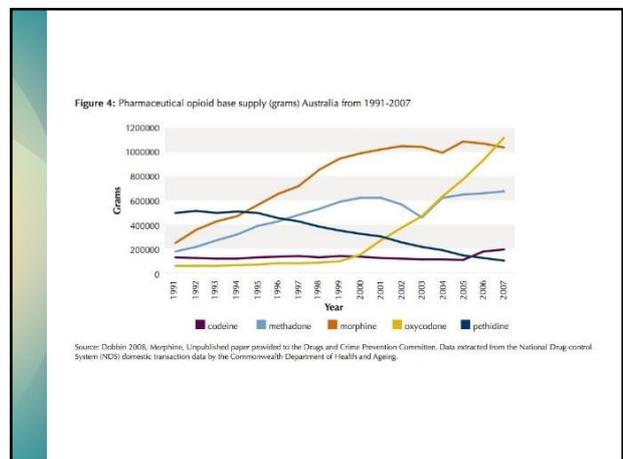
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### NAS management

- NAS scoring is usually a modification of the Finnegan scoring system
  - Systematic assessment of symptoms
  - Establishes the diagnosis of NAS
  - Describes the severity of symptoms
  - Assesses the efficacy of pharmacological therapy for appropriate dosing and titration

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### Sample Neonatal Narcotic Abstinence Scoring Sheet

Newborn Nursery - NICU

SYSTEM	SIGNS AND SYMPTOMS	SCORE	DATE	
			INITIAL	FINAL
CENTRAL NERVOUS SYSTEM/BEHAVIOR	Excessive high-pitched (not infant cry)	1		
	Excessive high-pitched (not infant cry)	1		
	Diaper 1-2 Hour After Feeding	1		
	Diaper 3-5 Hour After Feeding	1		
	Hyperactive Moro Reflex	1		
	Mildly Irritable Moro Reflex	1		
	Mild Tremor Observed	1		
	Moderate - Severe Tremor Observed	1		
	Mild Tremor Undisturbed	1		
	Moderate - Severe Tremor Undisturbed	1		
AUTONOMIC/RESPIRATORY DISTURBANCES	Exaggerated Grimace	1		
	Exaggerated Jerks of Head	1		
	Exaggerated Grimace	1		
	Exaggerated Jerks of Head	1		
METABOLIC/HAEMODINAMIC/RESPIRATORY DISTURBANCES	Swallowing	1		
	Apnea < 15 sec (or 45 sec if 1st, 4th, 8th, 12th, 16th)	1		
	Apnea > 15 sec (or 45 sec if 1st, 4th, 8th, 12th, 16th)	1		
	Respiratory Rate < 30 (or 4 times per interval)	1		
	Respiratory Rate > 30 (or 4 times per interval)	1		
	Respiratory Rate < 30 (or 4 times per interval)	1		
	Respiratory Rate > 30 (or 4 times per interval)	1		
	Respiratory Rate < 30 (or 4 times per interval)	1		
	Respiratory Rate > 30 (or 4 times per interval)	1		
	Respiratory Rate < 30 (or 4 times per interval)	1		
TOTAL SCORE				

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### Non-pharmacologic treatment

- Providing “skin to skin” contact with the parents
- Swaddling, holding, and rocking by the parents and/or staff (including the cuddling service)
- Reducing bright lights
- Minimizing excessive environmental noise
- Placing a small roll in between the legs if they cross because of increased muscle tone
- Making sure the babies sleep on their back
- Providing non-nutritive sucking
- Increasing calorie to 24 kcal/oz formula, if indicated

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### Pharmacologic treatment

- Estimate 65-85% of babies with NAS need pharmacological treatment
- Pharmacologic treatment regimes vary by location
- Oral morphine is very often used as the primary agent
- Other agents added (e.g. Phenobarbital) as needed

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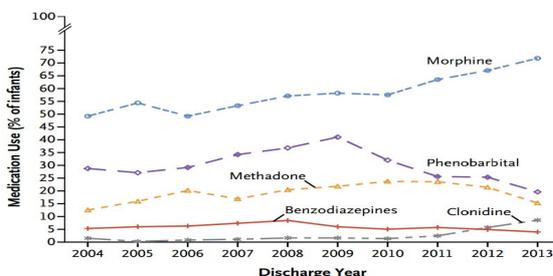


Figure 3. Medication Use in Infants with the Neonatal Abstinence Syndrome.

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### Comparing and Contrasting Alcohol Use and Opioid Use During Pregnancy

	Opioid Use During Pregnancy	Alcohol Use During Pregnancy
Prevalence of use	1.6%-8.5% of pregnant women use opioids; however, it's on the rise. <sup>1</sup>	Approximately 8.5% of pregnant women drink alcohol at some point during pregnancy. <sup>1</sup>
Likelihood of developing	NAS is seen in 30-80% of infants born to women who used opioids in the third trimester. <sup>2</sup>	2.5% of school age children may have FASDs. <sup>3</sup>
Negative effects/disabilities	Neonatal Abstinence Syndrome (NAS) <sup>4</sup>	Fetal Alcohol Spectrum Disorders (FASDs) <sup>1</sup>
Duration of effects	Unknown <sup>4</sup>	FASDs last a lifetime <sup>5</sup>

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### Comparing and Contrasting Alcohol Use and Opioid Use During Pregnancy (Continued)

	Opioid Use During Pregnancy	Alcohol Use During Pregnancy
Cost of care	Average of \$90,000 per case of NAS <sup>8</sup>	Estimate \$1.2-2.5 million per case of FAS <sup>7</sup>
Screening and brief intervention	Universal screening using the 5P's tool, and brief intervention <sup>9</sup>	Universal screening using the AUDIT (US) tool, and brief intervention <sup>9</sup>
Ethics	Avoid separation of mother and child. <sup>10</sup>	Avoid separation of mother and child. <sup>10</sup>
Treatment	Medication-assisted therapy (MAT) <sup>2</sup>	Appropriate treatment referral for alcohol use disorder*

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### Interacting with a family

- Recognize that the substance abusing parent is a whole person with dreams, desires, and strengths, as well as weaknesses
- Acknowledging that "substance abuser" is just one aspect of a person's identity can be the basis of a helping alliance different from others the parent has experienced

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### Interacting with the family

- Many places consider use of substance during pregnancy indicative of child abuse or neglect
- My opinion is that incarceration or the threat of incarceration is not effective in reducing perinatal substance use

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### Audience participation...

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### Statement #1

- There is safe use of alcohol during pregnancy

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### No safe alcohol use during pregnancy

- There is **no amount** of alcohol during pregnancy that is risk-free
- There is **no kind** of alcohol during pregnancy that is risk-free
- There is **no time** during pregnancy when alcohol consumption is risk-free

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### Statement #2

- We don't see these types of mothers

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### Who Drinks During Pregnancy?

- Women who drink during pregnancy come from all social, economic and ethnic groups
- Nationally, 1 in 10 women report alcohol use during pregnancy



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### Who Drinks During Pregnancy?

- Among pregnant women, the highest prevalence of reported alcohol use was among those who were:

- Aged 35-44 years
- College graduates
- Unmarried

Tan CH, Denny CH, Cheal NE, Sniezek JE, Kanny D. Alcohol use and binge drinking among women of childbearing age - United States, 2011-2013. MMWR Morb Mortal Wkly Rep. 2015;64(37):1042-1046

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### Statement #3

- There is nothing you can do about PAE or an FASD

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### Potential Benefits of Screening

- Discussing the cause with a biological mother may reduce recurrence risk in future offspring
- *Reduction* of stigmatization through accurate medical diagnosis *and* *supportive counseling*

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### Resources

- American Academy of Pediatrics (AAP): [aap.org/fasd](http://aap.org/fasd)
- Centers for Disease Control and Prevention (CDC): [cdc.gov/ncbddd/fasd](http://cdc.gov/ncbddd/fasd)
- National Organization on Fetal Alcohol Syndrome: [nofas.org](http://nofas.org)
- National Institute on Alcohol Abuse and Alcoholism: [niaaa.nih.gov](http://niaaa.nih.gov)

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## Take Homes

- FASD are PRIMARY CARE diagnoses
- Obtaining a history of possible prenatal alcohol exposure should be routine
- Neurodevelopmental/neurobehavioral problems far more common than physical features
- A comprehensive physical and behavioral assessment will yield a clear path to treatment

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## Take Homes

- Illicit substance use during pregnancy remains constant
- Prescription medication use during pregnancy is increasing
- Infants with NAS are increasing nationally and locally
- Non-pharmacological management is the first line of treatment for infants with NAS
- Morphine is the most common drug used to treat infants with NAS

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## Questions?



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