

Selected Lectures of the Meeting “Family Pediatrics between the present and the future”

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LECT 1

FAMILY PEDIATRICS: PRESENT AND FUTURE

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Primary Care Pediatrics represents one of the defining elements of Italian pediatric care: a model built on proximity, continuity of care, a relationship of trust, and a longitudinal knowledge of the child, the adolescent, and their family. This is its "genetic code," which must be preserved even in the face of the profound transformations affecting the Italian National Health Service.

However, preserving the identity of Primary Care Pediatrics does not mean keeping its organizational models, skills, and tools unchanged. The health needs of the developmental age are changing: alongside the management of acute illnesses, prevention, chronic conditions, neurodevelopmental disorders, mental health, social vulnerabilities, overweight and obesity, adolescent issues, and new family needs are gaining increasing relevance. From discharge from the maternity ward – which does not mark the end of a journey, but rather the moment when continuity of care extends into the community – up to adolescence, the Primary Care Pediatrician is called to accompany an increasingly articulated and complex health trajectory.

At the same time, the tools of the profession are also evolving: first-level diagnostics, point-of-care testing, ultrasound, screening, telemedicine, digital systems, and artificial intelligence can expand the capabilities of the Primary Care Pediatrician's clinic, bringing expertise and services closer to the child and the family.

Technology and the doctor-patient relationship are not alternatives, but complementary. Technology gains value when it enhances the paediatrician's ability to prevent, diagnose, make decisions, treat and monitor, whilst keeping professional judgement and the relationship of trust with the child and their family at the centre.

The future requires rethinking the boundaries of pediatric care, considering care management up to the age of 18 to ensure treatment and prevention during a crucial stage of growth.

Primary Care Pediatrics will need to evolve while remaining competent, organized, and connected, without losing proximity, accessibility, and continuity.

The challenge is not to change the genetic code of Primary Care Pediatrics, but to enable its transformation. Not to turn the Primary Care Pediatrician into something different, but to create the conditions for them to fully fulfill their role within the Italian National Health Service, equipped with skills and tools tailored to new needs. Based on this vision, the Italian Federation of Pediatricians (*Federazione Italiana Medici Pediatri – FIMP*) intends to contribute to building the Primary Care Pediatrics of the coming years – one capable of accompanying children, adolescents, and families, and building the health of future generations today.

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LECT 2

COMMUNICATION AND LANGUAGE ERRORS IN THE CARE RELATIONSHIP

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"Doctor, to tell you the truth..."

Whenever I hear these words, I am reminded of a solemn formula:

"I swear to tell the truth, the whole truth, and nothing but the truth."

In this formula, we can already recognize, by contrast, three different ways in which the truth can be altered: by omitting, adding, or modifying. Communication errors are made of the very same material: errors of omission, commission, and manipulation. There is, however, one fundamental

difference: errors often lack intentionality and are instead driven by cognitive, perceptual, and linguistic automatisms of which we are not fully aware.

For this reason, in the doctor-patient relationship, we must learn to slow down and make time to reflect on how we think, how we speak, and, above all, how we can get things wrong. Understanding our errors means learning how to prevent them and, when they do occur, how to repair the relationship. This presentation aims to transform the audience into a small experiential laboratory, seeking to create a corrective emotional experience. Through perceptual illusions, cognitive games, and illusionistic techniques, images and strings of words will appear and disappear, revealing how what we see, remember, and communicate may differ from what we believe. As Sigmund Freud wrote in *A Difficulty in the Path of Psycho-Analysis* (1917), “the ego is not master in its own house.”

Within each of us coexist an experiencing self, which lives through what happens, and a remembering self, which selects, reconstructs, and preserves the story of what has happened. Understanding the distance between these two selves means beginning with self-knowledge, even before turning to communication techniques.

We are stories in motion. And in the care relationship, speaking the same language is not enough: we must learn to listen methodically. Because in the words, silences, hesitations, and stories of families, very often, the diagnosis is already there, waiting to be heard.

LECT 3

COMPLEMENTARY FEEDING IN PRETERM INFANTS: A NUTRITIONAL AND NEURODEVELOPMENTAL PROCESS

C. Argentina

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Complementary feeding in preterm infants is an increasingly relevant clinical issue, owing to improved survival of very preterm infants, their greater neurodevelopmental complexity, and their specific nutritional vulnerability. The transition from milk feeding to complementary foods should therefore not be regarded merely as a nutritional step, but as part of a broader process of sensory, motor and neurodevelopmental maturation.

The fetus is a multisensory being, and the different sensory systems develop according to a predetermined sequence. Preterm birth profoundly modifies this experience: relatively immature systems, such as auditory, visual and nociceptive pathways, may be exposed to excessive and premature stimulation, whereas more mature modalities, including tactile, vestibular, proprioceptive, olfactory and gustatory systems, may receive insufficient stimulation. This altered sensory experience may contribute to difficulties in acquiring feeding skills.

Preterm infants also have a different body composition from term infants, with a relative deficit in lean mass and greater susceptibility to nutritional deficits. Complementary feeding should therefore provide adequate energy and nutrient density, progressively adapted to individual growth and developmental needs.

The timing of complementary feeding should be individualized and based not only on chronological age, but particularly on corrected age and neurodevelopmental readiness. It may generally be introduced between 5 and 8 months of chronological age, but not before 3-4 months of corrected age and, approximately, after 52 weeks of gestational age. Essential prerequisites include adequate head control, the ability to maintain a sitting position, even with support, the ability to bring the hands to the mouth, interest in food, and effective milk feeding.

Complementary feeding should therefore be considered a neurodevelopmental milestone, introduced gradually while respecting the infant's abilities and progressively increasing dietary variety and nutrient density. Particular attention should be paid to the prevention of nutritional deficiencies, with iron and vitamin D supplementation according to individual needs and, in general, at least throughout the first year of life.

An additional challenge is represented by alternative dietary patterns, including vegan, lacto-ovo-vegetarian and pescatarian diets. In preterm infants, whose nutritional requirements are high and vulnerability to deficiencies is greater, these diets require careful assessment and expert supervision. In particular, an inadequately planned vegan diet may increase the risk of deficiencies in vitamin B12, iron, zinc, calcium, iodine and vitamin D. Such dietary choices should therefore be discouraged when not adequately balanced or, when desired by the family, undertaken only under the supervision of a pediatrician with specific nutritional expertise. The first 1,000 days represent a critical window for

growth, development and metabolic programming. In preterm infants, complementary feeding should be considered an integral part of clinical care and follow-up. Current evidence suggests that the timing of complementary feeding *per se* does not determine the subsequent risk of overweight or obesity, and there is no reason to delay the introduction of allergenic foods. The goal is therefore not to rigidly accelerate or postpone complementary feeding, but to identify the moment when adequate neurodevelopmental readiness has been achieved while ensuring an appropriate quantitative and qualitative nutritional intake.

LECT 4

NEW INSIGHTS IN PEDIATRIC NUTRITION

R. de Franchis

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Early nutrition during the first 1,000 days of life is a major determinant of long-term health programming. Increasing evidence indicates that the quality of complementary feeding influences gut microbiota development, immune maturation and future metabolic health. Within this context, complementary feeding represents a unique opportunity to establish healthy eating behaviours from the earliest stages of life.

To investigate the long-term effects of complementary feeding quality, the Working Group on Mediterranean Diet in Pediatrics of the Naples Section of the Italian Federation of Pediatricians (*Federazione Italiana Medici Pediatri – FIMP*) conducted a prospective study involving 394 infants, comparing two complementary feeding models: a conventional approach based on commercially prepared baby foods and a Mediterranean diet-based approach using exclusively fresh family foods, with extra virgin olive oil added after cooking and no added salt.

Children were re-evaluated at 5 [1] and 9 years of age [2]. At both follow-up assessments, those who had received the Mediterranean complementary feeding model showed a gut microbiota profile more consistent with eubiosis. At 9 years, although statistical significance was not reached because of the reduced sample size, a protective trend was observed for selected chronic inflammatory and neurodevelopmental disorders, including atopic dermatitis, eczema, autism spectrum disorder and

ADHD. In addition, these children showed a higher consumption of vegetables than those who had received conventional complementary feeding.

Overall, these findings suggest that the quality of complementary feeding, particularly when based on the Mediterranean diet, may positively influence early health programming while promoting healthier dietary habits later in life. They also highlight the pivotal role of family pediatricians in guiding infant feeding practices and supporting the development of lifelong healthy eating behaviours. Notably, this Mediterranean complementary feeding model anticipated current international recommendations advocating the use of fresh, minimally processed foods during complementary feeding and is fully consistent with the Developmental Origins of Health and Disease (DOHaD) framework, which recognizes early-life nutrition as a cornerstone of lifelong health [3].

Finally, this study highlights the unique potential of Italian family pediatricians to conduct practice-embedded research by integrating clinical care and research within routine primary care practice, generating real-world evidence to improve child health.

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LECT 5

POLYMETHYLSILOXANE POLYHYDRATE (ENTEROSGEL KIDS®) IN THE TREATMENT OF ACUTE DIARRHEA IN CHILDREN

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Acute diarrhea is one of the most common causes of discomfort in children. It can lead to dehydration,

abdominal pain, and general malaise, placing a substantial burden on families. Oral rehydration and continued appropriate feeding remain the mainstays of treatment [1, 2]. Nevertheless, shortening the diarrheal episode and relieving associated symptoms remain clinically relevant goals.

Polymethylsiloxane polyhydrate (PMSPH; Enterogel Kids®, Guna S.p.A., Milan, Italy) is an enteroadsorbent medical device that acts through physical and mechanical mechanisms. It binds toxins, endotoxins, enterotoxins, and potentially irritating metabolites in the intestinal lumen, facilitating their elimination in the stool without affecting intestinal motility or systemic absorption [3].

This single-center, retrospective observational study, conducted in a family pediatric practice within ASL 8 in Arezzo, Italy, between May and August 2026, assessed the clinical course of children with acute diarrhea treated with Enterogel Kids® in routine practice. Clinical diaries from 58 children aged 1-13 years were analyzed. Children were divided into two groups according to age and the dosage administered: Group 1 comprised children aged 1-6 years, and Group 2 comprised children older than 6 years. Each group was further divided into subgroups according to the presence or absence of abdominal pain. Outcomes included the mean number of bowel movements per day, stool appearance and consistency assessed using the Bristol Stool Form Scale, and, in children with abdominal pain, pain intensity assessed using a visual analog scale.

The combined outcome measures were used to describe the mean duration of the diarrheal episode. In all subgroups, the number of daily bowel movements decreased rapidly, with mean values falling below the clinical threshold for diarrhea by the third day of observation. Among children aged 1-6 years, the mean episode duration was 2.55 days in those with abdominal pain and 2.22 days in those without pain. Among children older than 6 years, the corresponding durations were 2.23 days and approximately 2 days. Stool consistency improved rapidly, changing from Bristol types 6-7 to values consistent with formed stools within 24-48 hours. In the subgroups with abdominal pain, pain intensity also decreased markedly within 48 hours. Overall, these findings suggest that Enterogel Kids® may be a useful, well-tolerated adjunct in the management of acute diarrhea in children, potentially helping to restore normal bowel habits and relieve associated symptoms.

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LECT 6

NEWS IN ENURESIS

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Enuresis (EN) is defined by the International Children's Continence Society (ICCS) as intermittent urinary incontinence during sleep in children older than 5 years. It may be classified as primary or secondary and as monosymptomatic or non-monosymptomatic, depending on the presence of lower urinary tract symptoms [1].

EN is one of the most common pediatric conditions, affecting 10-20% of children at 5 years of age, 5-10% at 10 years, and about 3% of adolescents. It is more common in boys, with a male-to-female ratio of approximately 2:1, and may persist into adulthood in 0.5-1% of individuals.

The etiology of EN is multifactorial and includes genetic predisposition, nocturnal polyuria related to insufficient nocturnal vasopressin secretion, detrusor overactivity, and impaired arousal mechanisms during sleep.

Diagnosis is based on a detailed medical history, physical examination, a voiding diary, and appropriate first-line investigations. Early identification of associated lower urinary tract dysfunction and comorbidities is essential for optimal management.

Treatment options include behavioral interventions, pharmacological treatment and EN alarm therapy. Recent advances in EN focus on a more individualized approach to treatment, greater recognition of clinical comorbidities, the development of prognostic tools such as the PiFe (Predictive index

For enuresis therapy) Score, and emerging evidence supporting tailored use of desmopressin and alarm therapy according to patient characteristics.

Clinically relevant comorbidities are present in 20-30% of affected children and include attention-deficit/hyperactivity disorder, cognitive impairment, autism spectrum disorder, obesity, constipation, and encopresis. These conditions may adversely affect treatment outcomes.

The recently proposed PiFe Score integrates clinical and prognostic factors to identify patients at increased risk of treatment failure or relapse and may support a more individualized therapeutic approach [2].

In children with monosymptomatic EN, desmopressin remains the first-line pharmacological option. Available formulations include oral tablets and oral lyophilisates (melt). Recent studies suggest higher complete response rates and lower failure rates with tablets compared with melt formulations after 12 weeks of treatment [3]. Overall, treatment is effective in approximately 75-80% of cases.

Early recognition and timely management are essential to reduce the burden of EN on quality of life and to minimize the risk of persistence into adulthood.

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LECT 7

DIABETES SCREENING: WHERE DO WE STAND?

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Type 1 diabetes (T1D) is a progressive autoimmune disease that may evolve silently for months or even years before the onset of clinical symptoms. The

identification of individuals at risk through screening therefore offers the opportunity to recognise the disease before symptomatic diabetes develops and to establish appropriate metabolic surveillance.

Several groups have a particularly high risk of developing T1D and represent the traditional target of screening programmes. These include first-degree relatives of individuals with T1D, subjects with other autoimmune diseases, and children or adolescents presenting with incidental or unexplained hyperglycaemia. In these populations, screening for islet autoantibodies can identify individuals with presymptomatic T1D and allows appropriate monitoring, education and psychological support.

However, most children who develop T1D do not have an affected first-degree relative or another recognised risk factor. This represents a major limitation of risk-based screening strategies and provides a strong rationale for considering population-wide screening.

Evidence from large population-based programmes is increasingly supporting this approach. The German Fr1da programme, the largest population-based screening study to date, screened more than 220,000 children and identified presymptomatic T1D in approximately 0.3% of the population [1]. Importantly, screening identified 81% of the children who subsequently progressed to clinical T1D, while the risk of progression was similar in children with and without a first-degree family history. Other programmes, including ASK in the United States, have similarly demonstrated the feasibility of screening children in the general population and the importance of identifying children who would not be selected by family-history-based strategies [2].

Italy has now moved from research to implementation. Following the introduction of national legislation for paediatric T1D and coeliac disease screening, the D1Ce Screen pilot programme is evaluating the feasibility, acceptability and sustainability of population screening within the Italian National Health Service. The programme involves 5,363 children aged 2, 6 and 10 years from four regions – Lombardy, Marche, Campania and Sardinia – and uses capillary blood sampling for islet autoantibody testing.

Population screening may therefore represent a paradigm shift from a reactive model, based on the diagnosis of symptomatic diabetes, to a proactive model, in which T1D is identified during its presymptomatic stages. Potential benefits include a substantial reduction in diabetic ketoacidosis at clinical diagnosis, improved metabolic status,

better preparation of children and families, and the possibility of offering disease-modifying therapies before symptomatic disease develops.

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LECT 8

UPDATE ON THE PREVENTION OF RSV INFECTION

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Respiratory syncytial virus (RSV) is one of the leading causes of lower respiratory tract infection in children, with a particularly significant impact on infants. Until a few years ago, preventive options were very limited: palivizumab was restricted to selected high-risk children, while no preventive strategy suitable for large-scale use was available for the vast majority of newborns. Management therefore relied primarily on oxygen therapy and supportive care. The situation has now changed profoundly, marking one of the most important advances in pediatric prevention. Maternal vaccination and passive immunization of infants with long-acting monoclonal antibodies are now available.

Maternal vaccination enables the transplacental transfer of antibodies, providing protection during the first months of life. In the MATISSE trial, RSVpreF showed 69.4% efficacy against severe RSV disease through the first 6 months of life.

Long-acting monoclonal antibodies have introduced a new prevention paradigm: a single administration can directly protect infants throughout their first RSV season. In the HARMONIE trial, nirsevimab reduced RSV-related hospitalizations by 83.2%.

In Spain, universal immunization has shown a pooled effectiveness of 84.4% against hospitalization for RSV lower respiratory tract infection. Data from Tuscany also confirm the substantial impact of this strategy. During the 2024-25 season, coverage exceeded 90% among both in-season and out-

of-season births, with an 82.1% reduction in hospitalizations in the target population.

A further area of interest is the second RSV season. Recent Spanish data have shown a reduction in recurrent hospitalizations among children immunized during the previous season and have not demonstrated evidence of a rebound in hospitalization rates. Our preliminary, as-yet unpublished data are also reassuring: among children immunized during the previous season, we did not observe a significant increase in hospitalizations during their second RSV season.

Nirsevimab and maternal vaccination are now joined by clesrovimab, recently authorized in the European Union. RSV prevention has therefore entered a new era.

In this new scenario, epidemiological surveillance continues to play a central role. Prevention is not the endpoint, but the beginning of a new phase: integrated surveillance will be needed to monitor infections, hospitalizations, disease severity, age distribution, and the effectiveness of immunization strategies, while promptly identifying any changes in the epidemiology of RSV. Only through robust and continuous data collection will it be possible to adapt prevention strategies and transform this major medical advance into increasingly effective and sustainable protection for all children.

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