

**Dr. Simonian's**  
**2007 Notes and Tips in Pediatrics**

**by**

*Mark M. Simonian, MD, FAAP*  
681 Medical Center Drive West #106  
Clovis, CA 93711  
559 325-6850  
*after hours: 221-3893*

**July 16, 2007**

**Published by**  
**MMS Publishing ©**

**I dedicate this book to Michaelyn and Scott**

<b>INTRODUCTION</b>	<b>11</b>
<b>ALLERGY</b>	<b>12</b>
Allergy	12
<b>CHILD BEHAVIOR</b>	<b>13</b>
Spanking	13
Spoiled child	13
Hyperactive children	14
Temper tantrum	14
What is a tantrum?	14
Bedwetting	15
The biting child	16
Your child's diet and stomach pains	16
School phobias	17
Bedtime	18
<b>FEEDING AND DIET</b>	<b>19</b>
Feeding and formula	19
How much formula?	19
Breast Feeding	19
Not eating enough	20
Nursing technique	20
Schedule for adding solid foods	20
Water	21
Circumcision	21
Vitamins, Orange juice, and Solid Foods	21
Vitamins and increased appetite?	21

<b>EYES, EARS, NOSE, THROAT</b>	<b>23</b>
Ears, Eyes, Nose, and Mouth	23
Earaches	23
Your child's eyes	23
Signs of problems <1 year old	23
Vision screening	24
Amblyopia	24
Cataract	24
Glaucoma	24
Tear duct	24
Ptosis	25
Blepharitis	25
Conjunctivitis	25
Corneal abrasions	25
Myopia	25
Hyperopia	25
Astigmatism	25
Swimmer's ear	26
Nose bleeds or epistaxis	26
Styes and chalazion	26
Blocked tear duct	27
Canker Sores	27
<b>ADOLESCENT PROBLEMS</b>	<b>28</b>
Adolescent females	28
Dysmenorrhea and premenstrual syndrome	28
Problems with the penis	29
Menstrual problems	29

<b>Vaginal discharge</b>	<b>30</b>
<b>DEVELOPMENT AND BEHAVIOR</b>	<b>31</b>
<b>Toilet training your child</b>	<b>31</b>
<b>Does your child stutter?</b>	<b>31</b>
<b>The first month</b>	<b>32</b>
<b>Motor activity</b>	<b>32</b>
<b>Two month old</b>	<b>33</b>
<b>The third month</b>	<b>33</b>
<b>HORMONES AND GLANDS</b>	<b>35</b>
<b>Thyroid</b>	<b>35</b>
<b>Premenstrual syndrome or PMS</b>	<b>35</b>
<b>Hepatitis</b>	<b>35</b>
<b>IMMUNIZATIONS AND VACCINATIONS</b>	<b>37</b>
<b>Who should get DPT vaccine?</b>	<b>37</b>
<b>What are the risks from DPT vaccines?</b>	<b>38</b>
<b>Mild DPT problems</b>	<b>38</b>
<b>Moderate DPT problems</b>	<b>38</b>
<b>Severe DPT problems</b>	<b>38</b>
<b>Pertussis or whooping cough</b>	<b>38</b>
<b>Tetanus (lockjaw)</b>	<b>39</b>
<b>Hemophilus influenzae</b>	<b>39</b>
<b>Polio</b>	<b>39</b>
<b>Polio vaccine</b>	<b>40</b>
<b>Who should get IPV?</b>	<b>40</b>
<b>What are the risks from polio vaccine?</b>	<b>41</b>
<b>Risks from IPV</b>	<b>41</b>

<b>MMR vaccines</b>	<b>41</b>
<b>Hepatitis B vaccine</b>	<b>43</b>
<b>Chicken pox vaccine</b>	<b>43</b>
<b>Immunization schedule</b>	<b>43</b>
<b>INFECTIONS AND CONTAGIOUS ILLNESSES</b>	<b>45</b>
<b>Fever</b>	<b>45</b>
<b>Fever Treatment</b>	<b>45</b>
<b>Coughs and Colds</b>	<b>45</b>
<b>Croup</b>	<b>46</b>
<b>Head lice</b>	<b>46</b>
<b>Chicken pox</b>	<b>46</b>
<b>Pink eye or Conjunctivitis</b>	<b>46</b>
<b>Bladder or urine infections</b>	<b>47</b>
<b>Bacteria vs. virus</b>	<b>47</b>
<b>Hand, foot, and mouth disease</b>	<b>47</b>
<b>Stomach flu or gastroenteritis</b>	<b>48</b>
<b>Roseola (baby measles)</b>	<b>48</b>
<b>Ringworm</b>	<b>48</b>
<b>Chronic fatigue in children.</b>	<b>48</b>
<b>Impetigo</b>	<b>49</b>
<b>Influenza or (FLU)</b>	<b>49</b>
<b>Jaundice with hepatitis</b>	<b>50</b>
<b>Lyme disease</b>	<b>50</b>
<b>Tuberculosis</b>	<b>51</b>
<b>Skin infections</b>	<b>51</b>
<b>Pinworms</b>	<b>52</b>
<b>Valley Fever</b>	<b>52</b>

<b>INCUBATION CHART</b>	<b>54</b>
Infectious Disease Incubation Chart	54
<b>SAFETY AND PREVENTION</b>	<b>56</b>
Safety Check List	56
Head injuries	56
Things kids choke on	56
First aid	57
Bike injuries	59
Swimming pool injuries	60
Roller-Blades, roller skates, or skateboard	61
Sprain	61
Smashed fingers and toes	61
Cuts	62
<b>STOMACH AND INTESTINES</b>	<b>63</b>
Vomiting > 24 hours.	63
Diarrhea	63
Constipation	63
Constipation treatment	64
Constipation in older children	64
Rectal pain, itching or bleeding	64
<b>RESPIRATORY PROBLEMS AND LUNGS</b>	<b>65</b>
Asthma	65
Smoking and your child	65
Secondhand smoke?	66
Bronchiolitis	66
<b>MEDICATIONS AND DRUGS</b>	<b>68</b>

<b>Antibiotic medicines</b>	<b>68</b>
<b>Medication dosing</b>	<b>68</b>
<b>Aspirin, Tylenol™, or Advil™</b>	<b>69</b>
<b>MISCELLANEOUS</b>	<b>70</b>
<b>Pain therapy</b>	<b>70</b>
<b>Infant sleeping position</b>	<b>70</b>
<b>Family Resources</b>	<b>71</b>
<b>Teething and fever</b>	<b>75</b>
<b>Irregular heart beat</b>	<b>75</b>
<b>Nintendo or Sega disease</b>	<b>75</b>
<b>Baby sitting reminders</b>	<b>76</b>
<b>Poisoning</b>	<b>76</b>
<b>MUSCLES AND BONES</b>	<b>78</b>
<b>Hernias</b>	<b>78</b>
<b>Bowlegs and knocked-knees</b>	<b>78</b>
<b>Flatfeet</b>	<b>78</b>
<b>Pigeon toes</b>	<b>78</b>
<b>Tibial torsion</b>	<b>79</b>
<b>Femoral torsion</b>	<b>79</b>
<b>Growing pains</b>	<b>79</b>
<b>Patellofemoral syndrome</b>	<b>79</b>
<b>Knee pain</b>	<b>79</b>
<b>Scoliosis</b>	<b>80</b>
<b>NERVOUS SYSTEM</b>	<b>81</b>
<b>Headache</b>	<b>81</b>
<b>NEWBORNS AND BABIES</b>	<b>82</b>

<b>Baths</b>	<b>82</b>
<b>Navel (umbilical cord)</b>	<b>82</b>
<b>Sleeping</b>	<b>82</b>
<b>Stools</b>	<b>82</b>
<b>Babies are babies</b>	<b>82</b>
<b>Books and resources</b>	<b>82</b>
<b>Colic</b>	<b>83</b>
<b>Crying babies</b>	<b>83</b>
<b>Jaundice of the newborn</b>	<b>84</b>
<b>False jaundice</b>	<b>85</b>
<b>OFFICE POLICY AND INFORMATION</b>	<b>86</b>
<b>Office visits</b>	<b>86</b>
<b>Telephone and on-line consultation</b>	<b>86</b>
<b>New financial policy</b>	<b>86</b>
<b>Scheduling</b>	<b>86</b>
<b>SKIN AND RASHES</b>	<b>88</b>
<b>Acne (newborn)</b>	<b>88</b>
<b>Acne (adolescent)</b>	<b>88</b>
<b>Diaper rashes</b>	<b>88</b>
<b>Birthmarks</b>	<b>88</b>
<b>Insect bites</b>	<b>89</b>
<b>Insect bite treatment</b>	<b>89</b>
<b>Hives</b>	<b>89</b>
<b>Facial rashes</b>	<b>90</b>
<b>Eczema or atopic dermatitis</b>	<b>90</b>
<b>Dry skin</b>	<b>91</b>
<b>Atopic dermatitis treatment</b>	<b>91</b>

<b>Cradle cap or seborrheic dermatitis</b>	<b>91</b>
<b>ADVIL AND MOTRIN TABLE</b>	<b>92</b>
<b>TYLENOL TABLE</b>	<b>93</b>

## **Introduction**

This booklet will help you meet the common needs of newborn babies and older children and adolescents. It provides helpful hints on how to keep your child healthy and happy. I hope it will be a good resource for you in those times when questions about your child arise.

Your child is a unique individual from the day he or she is born. Adapt these instructions to your child. Do not depend on friends and relatives. I will be happy to answer your questions while you are in the hospital or later by phone and during your visits to my office. Through the year, I will give you detailed instructions for your child.

I will remind you that my **Web site** has lots of links to health information that I think is best for your child. The Web site also allows you to record your child's health information for times when you might have more than one doctor. This personal health record can be shared with any doctor you choose or you may keep it private for your family use only.

<http://www.markmsimonian.medem.com>

If your child has been seen in the office and is currently an active patient, you also have available access to some of your child's records through another link.

<http://www.msimonianmd.com>. You can obtain summary of information on vaccines received, allergies, medications, some billing summaries and more.

## Allergy

### Allergy

Many families recognize that their children suffer from itchy noses, sneezing, nasal congestion, and post-nasal drip. Mostly, parents are annoyed by the constant sniffing, tearing, rubbing, and agitation hay fever provokes.

Certain times of year hay fever is an often mentioned but is more accurately described as allergic rhinitis or allergic conjunctivitis. Hay fever is not a fever following the exposure to hay. Hay fever is an allergic reaction occurring along your nasal passages or eyes. A reaction triggers the release of histamine. This chemical produces swelling, itching, and a mucous discharge. It is not always easy to determine the trigger for hay fever. A great deal of detective work might be necessary.

Although many parents believe hay fever is a problem during the spring, it will depend on the child's reaction to pollen, dust, or specific allergy-producing foreign proteins. Any season or all seasons can produce the unwanted symptoms.

The allergies might not cause most of the severe symptoms, but produce an environment for the development of secondary infections like sinusitis, otitis media, or asthmatic bronchitis.

#### *Treatment:*

The most common type of oral medications includes decongestants and antihistamines. A decongestant should reduce the swelling sufficiently to allow easy air flow through the nose. Antihistamines block the release of histamine and reduce the itching, swelling, and dry the mucous discharge. I like to recommend a combined medication. For a few children side-effects from these drugs can be more annoying than the disease. Sleepiness, hyperactivity, or agitation can bother some, but these symptoms are often dose-related so you can lower the dose and still benefit from the medication. In other situations the side effects become less noticeable over a few days or a week. I do not like to prescribe these medications for small infants four months or younger.

Topical decongestant sprays or drops help reduce the redness in the eyes or the swelling in the nose. Afrin™ or Neosynephrine™ are common brands used as nasal sprays. Visine™ is a common eye drop for irritated, itchy eyes. Afrin™ or Neosynephrine™ should not be used for more than few days, because a rebound effect will emerge, and the original swelling can reappear and become worse. Other nasal sprays and eye drops are available by prescription. These work by interfering with the allergic reaction. Some children are comforted by a salt water or saline solution that can soften the dry mucous and irrigate the nasal passage.

Testing for allergies can be done by an allergist. I will be happy to discuss this with you, if you feel that your child suffers from symptoms that are not relieved by conservative treatment.

*Last reviewed July 16, 2007*

## Child Behavior

### Spanking

When I discuss spanking, I am not referring to punishment. One or two light slaps on the “bottom,” light pinches or squeezes, serves the purpose of getting your child’s attention. It is not for punishment. Instead try “time outs,” withdrawal of favors or avoidance. If there are tantrums, and your child could get hurt or hurt others, pick your child up and put him or her in a “time out” spot or place where he or she can’t get hurt. Spanking an adolescent can be counterproductive. Withdrawal of privileges works most of the time and bargaining can produce good end results.

Never use belts, sticks or other hard items which could injure your child.

In today’s environment parents sometimes are reluctant to control their children for fear of abuse charges, but firm measures are sometimes needed to distract your child and get them on-track to appropriate behavior outside the home.

*Last reviewed July 16, 2007*

---

### Spoiled child

Spoiled children are inconsiderate of others, demand to have their own way, find it difficult to delay gratification, and are prone to temper outbursts. They are difficult to satisfy and do not remain satisfied long. They are unpleasant to be around, even for those who love them. One often gets the impression spoiled children do not enjoy being with themselves.

A common misconception is children are spoiled by overindulgence. Indulging children is one of the joys of being a parent or grandparent. Instead, spoiling results when you give material things, accept behavior without critical review or fail to provide essential guidelines for acceptable behavior.

Some parents believe it is abnormal for infants to cry except when they are hungry or need changing. Most young infants cry two hours or more a day, perhaps to relieve normal daily tension. Parents worry that holding their fussy baby will *spoil* or make the baby excessively demanding in the future. Research indicates colicky babies benefit from increased holding and interaction. However, after three to four months of age, infants may use crying in a manipulative way.

Many parents are unprepared for their child’s intense curiosity and urge to explore the environment. Parents find themselves following children around, cleaning up messes and snatching them away from danger. Every comment seems to be “no!” Parents begin to believe the worst — their child is spoiled. They attempt to regain control by increasing the severity and frequency of punishment. The child is then repeatedly frustrated by normal impulses which create a state of continuing conflict. Parents should be forewarned of this developmental stage and not aggravate the situation by overreacting. A toddler’s curiosity is normal and not a behavior problem.

Parents should child-proof their homes. With most of valuables and fragile items put away, you can give your child the freedom to learn without worrying that your child will hurt himself or herself or other household items.

Young infants have difficulty distinguishing between themselves and the people around them. At two years, infants start to develop more autonomy and an awareness of his ability to make decisions and influence events around them. This period is often described as the “terrible twos,” and applies from 18 months until three years. During this stage, children resist efforts to control activity. Parents may think this resistance to their authority is an indication their child is becoming spoiled. In fact, negative two-year-olds really are showing they have minds of their own. The parent should try to avoid conflict and confrontation. Don’t offer a choice of actions when there is no choice. Don’t ask the child to say how he or she feels when in the end it will make no difference. Let your child know about what action is expected firmly

and calmly. When appropriate, let your child make a choice when either choice is acceptable. This allows your child to feel some degree of control without your giving up any authority.

---

## Hyperactive children

A hyperactive child worries parents, gives teachers a headache, and is a common concern parents ask about during office visits

A diagnosis often attached to a true hyperactive child is Attention Deficit Hyperactivity Disorder. Many different behaviors are included in this disorder. It may be caused by a problem with the development of the central nervous system (brain). There may have been a chemical and structural imbalance in the brain that has been exacerbated by the child's environment. No chemical tests exist to determine the extent of problems in the brain. Psychological screening can help determine if this disorder is present.

Hyperactive children are excessively impulsive. These children have negative attitudes, great emotional up-and-down mood swings, and are difficult to discipline. Negative attitudes result in loss of self-esteem and may lead to behaviors ranging from boastfulness to delinquency. These behaviors complicate the child's healthy development. Only a minority of these children "outgrow" their symptoms completely or do very well despite their problems. Many are plagued by antisocial behavior patterns, chronic underachievement, problems with substance abuse, and even criminal behavior.

Treatment of this condition has proven to be very difficult. Children do better if they grow up in a stable home environment where adults provide structure and consistency. Discipline must be firm but not physical or verbally abusive. This special approach to discipline must be applied to school and home settings throughout the child's developing years.

The only chemical treatment that seems to benefit a majority of these children is central nervous system stimulants such as Ritalin, Concerta, Adderal, or Metadate. There are additional medications that may have beneficial results without requiring a controlled substance prescription. All these medications change the child's behavior briefly while the medicine is in the system. Side effects may be seen, but they will disappear after the medication is discontinued. Medications alone is not my approach for most children and adolescents without other psychological treatment. My policy is to evaluate whether there are other complicating conditions that provoke the symptoms like depression. Most of the dire consequences of Ritalin publicized by the media confuses the side effects of the medication with the symptoms of the disorder. Currently recommendation from professional pediatric societies like the American Academy of Pediatric recommend that one of these medication be considered along with other psychological therapies.

*Last reviewed July 16, 2007.*

---

## Temper tantrum

Temper tantrums are as difficult for children to deal with as they are for those around them. Children scream and loose control because they cannot have their own way. You may feel angry, frustrated or even scared. You may wonder what you have done wrong. Rest assured, almost all youngsters have tantrums between the ages of one and three years. Tantrums are a normal part of growing up and they will stop before the age of four. If your child has angry outbursts after that age you should call our office for an appointment or seek an evaluation with a psychologist experienced in evaluating children.

---

## What is a tantrum?

Young children are eager to take control. They want to be independent and they want to do more than their skills and safety allow.

They also want to make their own choices and do not cope well with disappointment or restraint. Some temper tantrums are for attention; others are to avoid doing something or to protest not having their own way. Tantrums are a child's way of showing frustration and anger.

Children of this age sometimes cannot fully understand their parents and other adults. They do not know all the words needed to describe their feelings and needs. Also, they have not yet learned to solve problems. Instead, they act out their anger and frustrations by crying and screaming, thrashing and head banging, breath holding, breaking objects, or being mean to

others. The following are examples of mild temper tantrums that can and should be ignored: crying and screaming for attention, whining to get attention (some find it helpful to say, "I can't understand you when you are whining. Please talk in a normal voice"). Minor displays of anger can include slamming doors, sticking out the tongue, or making faces, or pounding or kicking the floor, wall or door.

Temper tantrums are like safety valves that let off steam when the pressure gets too high. Parents need to accept that temper tantrums are a result of the child's inner struggle in growing up. They are normal and an expected part of a child's development.

*What to do?*

When your child has a temper tantrum, *try* to remain calm. If you are loud and angry your child will copy you. Shouting at them to calm down may make the situation worse. Stay peaceful. Most of all, do not get upset or angry with your child or hit or spank them. Temper tantrums should be ignored unless your child is damaging things. In a public area it is appropriate to remove your child as a courtesy to the people around him or her.

Some temper tantrums are too violent for parents to ignore. When this happens, children should be taken away from the scene of the tantrum to another room. A parent should stay with them. These types of temper tantrums include such behavior as: hitting or kicking parents or others; throwing things; continued screaming or yelling; and having tantrums in public places.

Consult me if your child shows any of the following signs: Tantrums continue or get worse after age four; injures self or others; destroy things during tantrums; has frequent nightmares; loses toilet training skills; frequent headaches, or stomachaches; clings to parents; displays persistent negative moods.

---

**Bedwetting**

Nearly 20% of five year olds frequently wet the bed at night and more than 10% of six year olds still wet the bed. Some three year olds, if taken for a late night trip to the bathroom, will make it through the night dry. Expect an occasional accident, but avoid punishment or threats of punishment. Children should not be kept in overnight diapers until they are 100% dry, because modern diapers are so absorbent they do little to encourage your child to develop any self control.

Children who have been dry for many months or even years may suddenly wet the bed. Children may regress because of the arrival of a new baby, a move or a severe stressful event. Occasionally a urinary tract infection is the cause of wetting, but there will be accompanying symptoms like frequency, burning or fever.

Bedwetting should not be considered unusual until your child is over 6 years. Try to remain calm and matter a fact. Most children are sensitive about the fact they have wet the bed. Your child often cannot prevent wetting the bed. Bladder control is a complex developmental and neurological process that occurs as children mature. Making the child feel guilty about bedwetting may only delay resolution of the problem. Be supportive of your child.

Your best course is to ignore the problem and wait it out. By seven years of age, you and your child may need to make a joint effort to solve the problem. Encourage fluids during the morning and afternoon, but discourage them several hours prior to bedtime. Have your child urinate just before bedtime. Fluids during the day ensure the bladder is big enough and urinating ensures it is as empty as possible at bedtime.

Try a reward system next. On a calendar, chart successes with stickers. Try this for weeks or months. If you do not see any progress, consider awakening your child in the evening after a few hours of sleep. This will empty the bladder and decrease the chances of wetting the bed. Adjust to an earlier hour if your child is already wet after waiting several hours. Older children who still wet the bed can help with laundering so they understand they are responsible for the consequences of their actions.

Alarm devices are useful in children, 8 and older. They can be obtained at most major department stores and medical supply houses.

A prescription nasal spray or tablet (DDAVP) helps many children who did not respond to other therapies. This drug is safe and has a good success rate. Treatment may require

---

**The biting child**

prolonged use depending on family history. The medication once started can produce a dry night the first night and be used just for special events like a night-over-at-a-friends.

Many parents ask me questions regarding their child who has been biting other children or family members. I read an article discussing biting children and hope you enjoy the summary of some of the important points.

“We never bite people.”

Biting is an unacceptable aggressive behavior. Parents are concerned about the dangers of infection. If your child bites a friend’s child he or she runs the risk of rejection from the friend’s home or at least severe embarrassment. Even more significant is when your child bites at a child care facility because most parents want a biter removed from their child .

Very young children under one year are teething, but older toddlers will bite when they are angry or frustrated.

Some suggested solutions include these following ideas. Establish a rule like “We never bite people.” Biting hurts and even a toddler understands the consequences of acts unacceptable to their parents.

Interrupt biting with a sharp “NO.” Be sure to use a displeased voice and look directly into their eyes. Try to interrupt biting if you catch him or her in the act. Close supervision can be very important,

Do not laugh when your child bites, and never treat it like a game. Other family members including older children should follow your rules. Don’t let your child’s threats of biting influence your own behavior by giving into the biters demands. Once you recognize the biting is more than random behavior and attempt to modify their behavior should begin right away. Discuss your plans for dealing with the biting with the child-care giver. they need to understand how you manage the problem and will follow your desires.

Suggest an acceptable substitute behavior. Tell your child he or she should come to you if they want something or need help. If your young toddler tends to chew everything provide toys that are design for the punishment and will not harm them. It would be a good idea to carry this chewable toys like a teething ring around for a short while.

If your child bites other people, send him to a boring place for a time out period. If he attempts to bite you say “NO” or give him a firm squeeze. Put him down and walk away. Another method is to deprive him of a favorite toy for a day.

Never bite him back. Biting back will make him mad that you hurt him and convince him that it is Okay to bite if you are bigger. Also, it is not appropriate to use physical force like slapping, pinching a cheek, or washing out the mouth with soap. If your child is aggressive, avoid all physical punishment such as spanking. Also avoid love bites, since your child will not be able to distinguish them from painful biting.

Praise your child for not biting. The most important time to praise is when he is around children he has bitten or in a similar situation where you anticipate he may bite again. Give him a kind reminder about biting just before the high-risk event and praise him after the event for his good behavior.

I would be concerned if this behavior persists for more than four weeks. I would be concerned if he bites himself and hurts himself intentionally. It is important to notify the office if you believe he or she has several other behavior problems.

*Last reviewed July 16, 2007*

---

**Your child’s diet and stomach pains**

Some children with persistent stomach pains, diarrhea, bloating, cramping, or excessive gas, have difficulty digesting certain foods

(carbohydrates ). Some of the common sources of carbohydrates, I have listed below. If your child was eating any of these foods lately, let me know. If I need to help your child, I can adjust some items in his or her diet.

One carbohydrate recognized to cause a problem for many children is called lactose . This is a sugar found in milk and all dairy products. These are a few examples of common foods containing lactose. Cow milk in most forms - whole, low fat, skim, condensed and butter milk. Ice milk or Ice cream, Mozzarella, and cottage cheese, Frozen yogurt, Milk-based pudding, macaroni and cheese

Other dairy products have a lower lactose content and are less likely to cause problems. I advise you to avoid them because children with intestinal infections can be particularly sensitive. Examples of these kinds of foods are: Most cheeses: American, Colby, Swiss, cheddar, Parmesan, Camembert, and cream cheese. Margarine that contains milk. Yogurt with active culture lactose is not the only carbohydrate that can cause stomach ache, diarrhea and cramps. In some cases symptoms can be caused by other carbohydrates like fructose and sorbitol.

Some common foods high in fructose are: Sodas sweetened by high-fructose corn syrup, fruits, chewy fruit snacks, fruit drinks and especially apple, grape and pear sherbets.

Foods high in sorbitol are:

- Apple juice and apple cider,
- Apples, prunes, pears and peaches.
- “Sugarless” candy or gum sweetened with sorbitol
- Fruit juice popsicles
- Fruit canned in concentrate apple or pear juice often labeled “lite.”
- Fruit juice drinks, Pear juice
- Medications flavored with sorbitol

Some foods labeled as high in fiber can cause intestinal symptoms too. Common foods like oat bran muffins or bread high-fiber breakfast cereals.

Some children are also bothered by an irritation of stomach fluid backing up into the esophagus. We are not surprised by newborns spitting up but older children may have similar complaints. Chronic bad breath or bad tastes in their mouth may be caused by the condition called gastroesophageal reflux (GERD). This can lead to persistent stomach pain. GERD can bother newborns and older children but there is effective medication to help alleviate the discomfort and control the symptoms. *Last reviewed May 15, 2007*

---

## School phobias

All children experience periods when they don't want to go to school. A school phobic child has many days when they miss school usually for vague reasons. The child does not act happy or well with symptoms common to anyone who is worried. These symptoms include vomiting, diarrhea, fatigue, headache, stomach, and dizziness.

These children are afraid of leaving home and growing up. They come from normal families who represent the best of child care and concern. They provide all that is needed to develop in a loving family. The child finds it difficult to leave home. Different reasons might appear on the surface such as a difficult teacher, a class bully or an embarrassing experience. The reason behind these superficial issues is the child lacks the self-confidence to leave home and develop on their own without the family or parents. Some children who seem to show the highest risks for this behavior is an only child, the last child or a child with chronic illnesses.

Treatment for this behavior can include these type of objectives. The child must return to school and must attend daily. After a very short time their confidence increases and their enjoyment of school increases. Expect your child to be reluctant to return to school and remind him or her of the importance of school. You are required to send them by state law and you or your child would not want to violate the law. Each day their confidence will increase and their reluctance will disappear. Each morning the child may complain of various complaints that increase as the time to leave for school approaches. Send them to school anyway. Don't ask about illness because that might set up a situation in which their complaints reappear. If one parent is better at the discipline necessary to enforce school attendance then it will be their task to be the primary person to reinforce the message for school attendance. It sometimes helps to travel to school with one or more school mates. If there are major concerns about the wellness of the child because of new complaints or severity of complaints then it would be important to have the child seen the same morning. If all is proven non serious then a return to school can be arranged later the same morning or at noon.

It will be helpful to discuss the situation with the school nurse who can reinforce the return to class after a brief rest or attention to the complaints. The school teacher will need to know

so that particular activities that produce great anxiety can be avoided in the beginning. The school is experienced with children who have fear of school because it is a common occurrence.

A useful tact to take is to increase your child's play time with classmates and school friends. It is understandable for parents who like to spend time with their children to be reluctant to give up precious hours. But it is essential to build up the child's self confidence away from the family structure and security. Consider invitations of classmates to the home. School related activities are encouraged.

Most school phobia is worked out over time without psychological or psychiatric counseling. If you feel you have exhausted all your options then I will be happy to discuss a therapist for the child and family.

*Last reviewed May 6,2005*

---

## **Bedtime**

A common question asked is what to do about toddlers who won't stay in bed and keep getting out of bed or calling for you. Many parents speak about the little amount of sleep their child is getting when the major concern is about the lack of sleep the parent is getting. It is obvious the child needs rest and will develop normally under routines and regular house rules. It will not help to beg, bargain or threaten. Attempting to reason with the child is natural but fruitless.

You must decide when it is appropriate for child to be put in his or her bed. You need your rest and time for yourself. Once you decided, set up a regular routine about the tasks that need to be done before bed and start some regular pattern you will follow nightly. An early evening snack may be the starting point of the end of the day, bathing or a story. However you set up your routine, I recommend a story or quiet time with your child before bed as a part of the routine. Kiss them good night and then no other excuses like a second glass of water, another story, bugs, furniture moving, monsters or reciting some earlier events are acceptable. If the child gets up quietly pick them up and return them to bed. This behavior might repeat itself over and over. You must quickly get up and return them to bed whether it happens five times a night or twenty times. It will be become apparent sooner or later you mean business. Please, don't give up or give in because you will have to start over at the beginning if you deviate from your pattern. Good luck, this always works. The suggestions for that 7 to 9 month old who wakes at night "to eat" or whatever is slightly different.

## Feeding and Diet

### Feeding and formula

You may offer 2 - 4 ounces of formula on demand to your newborn. Burp baby at least once during the feeding and at the end of the feeding. Always hold your baby and the bottle; never prop the bottle or use a bottle holder. Test the nipple before feeding the baby. The hole should be large enough to permit the formula to drip freely from the nipple when the bottle is held upside down without shaking the bottle. If the nipple hole is too small, enlarge it with a pin to increase it to the proper size. The bottle cap must be loosened so that air will enter the bottle freely. An alternative is the plastic liner type that decreases the amount of air a baby may swallow. Keep the nipple hole free from clogging with a tooth pick as needed. If these small precautions are not taken, the baby may tire before its hunger is satisfied and your baby will want to eat more frequently. It is not necessary to sterilize the formula or water. Bottles and nipples should be rinsed with hot sudsy water. Use at room temperature. When you use room temperature formula, set out another bottle so it can warm up for the next feeding. It will not harm the formula to warm it in water or the microwave. If you microwave the liquid, it can become hotter than the moment you stopped the oven. Let the bottle rest for two minutes and test it before using it.

---

### How much formula?

The amount of formula your baby takes will vary. Just like you and I, babies have the right not to be hungry, but you can't make a baby want to eat. Feeding schedules are best when they are roughly set and the baby is allowed to eat when he or she becomes hungry. Most babies will awaken for feeding every 2 - 4 hours; most will feed for 15 to 20 minutes. Babies may take all or just some formula. Don't worry. This is normal. As your baby grows and gains weight, he or she will need more formula. When your baby takes the entire bottle regularly and sometimes cries for more... increase the amount of formula in each bottle. Wake your baby every 3 to 4 hours during the day (8:00 A.M. to 8:00 P.M.) the first week or until you establish some feeding pattern where daytime feeding are more frequent. It is not necessary to feed this often, but the more the baby is awake during the day the better the baby will sleep at night.

---

### Breast Feeding

Breast feeding is the natural way to feed your baby. You and your baby will benefit from nursing. A breast fed baby may have fewer infections and fewer allergies and the nursing mother will benefit because her figure returns to normal faster. Most women can successfully nurse their babies. Successful nursing requires that the mother be relaxed and rested. This is absolutely necessary; but even under ideal conditions, it takes several days for a full milk supply to develop. There is not always a lot of colostrum so the baby might not seem completely satisfied. It is the extra desire to nurse longer that induces the milk production. If mother or baby seem too uncomfortable with the amount of colostrum then you can supplement with water, formula, or both. You need not use a bottle to supplement the feeding. A medicine dropper, medicine cup, or medicine spoon may be used to give fluids to the baby. Don't be impatient. Your baby will get plenty to eat and probably will want to eat often (every two to three hours).

Certain foods the mother eats may cause stomach upset or fussiness in your baby, such as : onions, garlic, the cabbage family of foods, chocolate, nuts, highly seasoned foods and large amounts of caffeine. Although these are the most notorious, almost any food can cause a reaction. Eat in moderation and if you suspect there may be a problem, keep a diary of your meals and your medications.

During the day, nurse about every four hours. Most newborns will nurse every two to four hours. Don't let them go more than four hours without trying to feed them. In the evening,

between 11 PM and 6 AM, they may be fed 2 to 3 times but may go for 5 to 6 hours between feedings. Avoid excessive fatigue and stressful activities because this can affect your milk supply. Get enough rest by setting a regular schedule of naps and adequate rest at night. Eat a well balanced diet and avoid excesses of any foods. Do not listen to old wives tales and superstitions you may hear from friends and relatives. Do the best you can. You have an excellent chance of being successful at breast feeding.

The first week of life can be extra stressful when your baby acts as if you cannot satisfy them. The nursery or floor nurse will help you get comfortable with nursing. If you decide to supplement with formula and are concerned about any confusion from taking the formula from a bottle then do this. Use a medication cup or small syringe to drip liquid into baby's mouth or let them lap it up from a cup. Don't try to pour it into the mouth. Nurses can show this technique for supplementation.

Parents frequently are concerned their baby is not eating enough.

*Last reviewed May 15, 2007*

---

### **Not eating enough**

If you are changing four to five diapers a day the first few days, you can rest assured

because your baby is getting enough to eat during the first week. You should be concerned in those first few days when your baby is wetting only one or two diapers every 24 hours. I encourage you to give some water or sugar water by cup or syringe to be sure they are receiving enough fluids.

Traditionally, parents view switching their baby from breast milk or formula to cow's milk as a major step in their development. This switch may cause serious nutritional consequences if made too early. Cow's milk does not supply the balanced nutrition that your baby requires during the first 9 to 12 months of life. You should continue to breast feed or feed a cow's milk formula like Similac™ or a soy formula like Isomil™ until I recommend otherwise. Any formula choices should be dictated by your child's health and family history of allergy to cow's milk or soy.

---

### **Nursing technique**

First get into a comfortable position. If you lie down you can feed the baby and rest at the same time. Stroking the baby's cheek and mouth with the nipple will stimulate the baby to open his or her mouth and turn toward the breast to grasp the nipple. Nurse from both breasts at each feeding time. Let the baby nurse from each breast for three minutes when you first start and increase the time by one minute every few times. Babies are normally sleepy during their first 48 hours of life. Until your nipples have toughened up, it is best not to nurse from the first breast for more than five minutes before changing to the other breast. Alternate the breast you start with at each feeding. Some mothers use a safety pin fastened to the bra side where they finished as a reminder for the next feeding.

Total nursing time to empty your breasts is usually 10 minutes. I recommend you start at three minutes on each breast and gradually work up to 10 minutes. This routine may take several days to a week to do.

To prevent sore nipples, avoid harsh soaps and irritating medications. Dove™, Nutragena™, or plain water work very well. Keep the nipples dry to prevent cracking. Avoid increased tension in the breasts by starting to nurse early and by nursing day and night. If the dark area around the nipple (areola) is too swollen for the baby to grasp easily, some milk should be manually squeezed out to reduce its size slightly. When nursing time is over, place your finger on the your baby's chin or press on the base of the nipple to relieve the suction. Now, the baby can be removed from the breast without hurting the nipple.

*Last reviewed May 15, 2007*

---

### **Schedule for adding solid foods**

At four to six months of age you may start adding solid foods like cereal. Rice or oat cereals are tolerated the best and are least likely to cause an allergic reaction. At six months you may start adding fruits and vegetables. Avoid corn and wheat, plus citrus like orange or lemon. Add only one new food each week.

You want to avoid allergic reactions like: pain, spitting up, vomiting, diarrhea, rash, runny nose, or cough. Do not force these new foods. If your baby refuses, stop for a few days and then resume. Your fresh, home-cooked foods, put into a blender or mixer, are the best foods for your infant. They taste better, have more nutritive value and cost less. Commercial baby foods are convenient but more expensive. Use plain foods for your baby. Avoid mixed dinners, mixed vegetables, puddings, cobblers, or desserts. They have less food value. To prepare these foods for future use you can blend a larger amount and fill an ice cube tray, freeze and put individual cubes in a freezer bag for future meals.

0-4 months Breast milk or Formula

4-6 months Cereal - rice or oatmeal preferred

6-8 months Vegetables: carrots, squash, sweet potatoes, green vegetables and fruits: applesauce, pears, peaches Your child hold a cup by 6 months so start off with a tippy cup

At 7 or 8 months, your infant can be introduced to soft table foods.

8-12 months eggs, meats, finger foods

From 8 to 12 months, babies eat more from the table. Feed them mashed or pureed foods or small bite sized finger foods that dissolve easily in the mouth (finger foods). Teething biscuits or Jell-O are fine. Avoid rich or seasoned foods. When starting eggs, remember: 2 to 4 eggs per week. Start with the yolks and then in a week, add the cooked white of the egg (This part of the egg is more likely to be a cause of egg allergy).

---

### Water

Offer one to two ounces of unsweetened water between feedings if your baby is fussy and not comforted when picked up or talked to soothingly. In our warm summer months, water may be offered if your infant has been exposed to warmer temperatures. Hiccups may be soothed by nursing, formula or water. Water does not need boiling and the bottle does not need sterilization. Do not add honey as a sweetener at any time **during the first year** because of the risk of botulism – a life-threatening infection. The risk disappears after this age.

---

### Circumcision

If your baby has been circumcised, apply Vaseline™ to the penis the first day or two only if the foreskin was removed. Notify me if marked bleeding or swelling occurs. Sometimes a Plastibell™ or plastic ring is used so no vasolene would be necessary. If a was used for the circumcision, no special care is needed. The ring will fall off in about one or two weeks.

---

### Vitamins, Orange juice, and Solid Foods

As long as your baby is nursing, taking formula or receiving supplementary vitamins with fluoride, there is no need for orange juice. Vitamin drops will provide an ample supply of Vitamin C for your baby so orange juice which contains Vitamin C is not needed. O.J. may cause allergies in small infants, so it is preferable to wait until 9 months or longer before starting it. Commercially prepared vitamins with fluoride will be prescribed at your child's six month visit. I will advise you when to start solid foods. My preference is to leave your infant on breast milk or formula exclusively for the first 4 to 6 months. Do not use cow's milk because of problems with adequate digestion, allergy and intestinal bleeding that can cause anemia. The earlier solid foods are started, the greater your infant's chances of having difficulties with future allergies or bowel problems.

---

### Vitamins and increased appetite?

Vitamins play an essential role in the body's machinery and basic chemical reactions. Without vitamins, individual human cells would stop functioning. When severe and prolonged deficiencies occur, many obvious and subtle changes can be all detected. These include rashes and skin changes, personality changes, disorders of organ functions, blood pressure variations, vision problems and many other symptoms.

One question that often arises during office visits or phone calls – my two or five year old's appetite isn't what it used to be; can this be improved with vitamins and minerals?

The human body is very efficient about how it uses these vitamins. It only requires small amounts of vitamins and minerals each day. The body grows at a certain rate, rapidly during

the first 9 to 18 months. Substantial amounts of foods are required to meet growth needs. When the rate of growth slows, the need for food decreases in the same proportion. Taking additional minerals and vitamins, will not increase growth beyond what has been determined by the baby's genetics. Vitamins don't control the body's rate of growth, and your child's natural appetite for foods won't increase with mineral and vitamin supplements. This does not apply to children with severe deficiencies of these essential elements, but these children are very rare in the normal population.

## Eyes, Ears, Nose, Throat

---

### Ears, Eyes, Nose, and Mouth

If matter accumulates in the corners of the eyes, wipe with a clean cloth or cotton balls dipped in water. You may gently clean the nose and ear canal openings with a moist Q-tip™. Do not stick the Q-tip™ into the ear or nose. This can cause impacted ear wax which can be uncomfortable and is difficult to see past when by a doctor tries to view the ear canal and tympanic membrane. Do not wash or wipe out the mouth although brushing teeth with water can start once teeth emerge. *Last reviewed May 15, 2007.*

---

### Earaches

Ear pain sometimes accompanies a cold. Earaches can go away in thirty minutes or up to a couple of hours without treatment. Using a portable hair dryer, try blowing warm air into the ear to relieve the pain. Propping your child up may also help reduce ear pain. Ear drops cannot cure common middle ear infections. You should make an appointment if pain lasts more than 10 minutes, if fever persists, or drainage from the ear or hearing loss occur. Although it has been estimated that 80% of ear infection should resolve without medications most pediatricians will treat children under two years with antibiotics.

---

### Your child's eyes

Your child's eyes is the title of a publication from the American Academy of Pediatrics on which this topic is based. We know that the earlier eye problems are discovered, the better the outcome. I too want the best possible vision for your child and would like you to read part or all of this article about guidelines for your child

Babies can see from birth. Their vision isn't developed completely though. The fine detail that will be achieved later is missing. Babies can distinguish bright colors well and are good at dark and light contrasts.

Babies can see small objects as early as 3 to 4 months. They can distinguish between some colors well, especially reds and greens. They can decide if a face is real or drawn.

At 4 months their eyes work in a fine, coordinated manner and have some depth perception.

---

### Signs of problems <1 year old

Your baby is not making eye contact between 2 to 3 months. Constant eye crossing or one eye that turns outward is probably abnormal. Babies over 3 months of age should be able to follow a moving object. You can test this by moving a brightly colored toy in front of their eyes, although you should avoid distracting them with your voice so you can get an accurate idea.

Older children might give different cues to their eye difficulties. If their eyes seem to be miss aligned crossing or straying outward or inward, you should call for an appointment to confirm the problem and get directed for consultation. This is a common problem and is usually corrected with glasses, but it can indicate other medical conditions.

Some children are noticed to have a white pupil. This can indicate anything from a cataract to a tumor of the eye. It requires your immediate attention and a call for a eye exam.

Other children can complain of eye pain or redness of the eye. This can be caused by a minor eye infection like pink eye or a more serious disease of the eye. I can usually determine the cause after a brief visit.

These are warning signs of eye problems that you could notice at any age:

Your child's eyes flutter up and down or side to side.

The eyes are always watery.

The eyes are always sensitive to the light.

Any change in the eye from their normal appearance

If you see white, yellow-white, or grayish-white material in the pupil

There is redness in either eye that does not go away in a couple of days

There is continued pus or crust in either eye

The eyes are crossed, turn out or don't focus

Your child often squints

Your child often tilts or turns his or her head  
The eyelids appear to droop  
The eye appears to bulge

---

### **Vision screening**

Vision screening starts with the my first visit in the hospital with your baby. Some babies were born prematurely or required prolonged periods of oxygen. I recommend an eye specialist for a detailed exam.

I check the alignment of babies eyes during the following six months.

By the age of 3 or 4 eyes are examined more closely and any history of problems is evaluated.

At the age of five a thorough eye screening is necessary. I am able to pick up problems with visual acuity screening and check for diseases of the eye.

Many infants appear to have eyes that appear crossed when they are not. This false crossing is caused by the normal widened bridge of the nose. Most children lose the appearance of the crossed-eyes as they grow.

Four out of every 100 children will have one or both eyes that are misaligned. One eye will look forward while the other turns inward, outward, upward, or downward. Some children are born with eye muscles that need lengthening or are too tight. Surgery is required to correct the problem. Other children have a problem with farsightedness and this causes their eyes to turn off at an incorrect angle. This can be corrected with glasses. Because children may compensate for poor vision in one eye, they turn off the vision in the weaker eye and this leads to Amblyopia (lazy eye) or loss of depth perception. In some rare situations a cataract or eye tumor can cause an eye to turn out of alignment.

---

### **Amblyopia**

Amblyopia is reduced vision in one eye because of lack of use. It occurs in one eye only. Any condition that interferes with normal vision can hinder the development of vision and result in amblyopia. About 2% of children are affected by Amblyopia. Some of the causes of Amblyopia are strabismus (eyes misaligned), droopy eyelids or ptosis, cataracts (clouding of the lens of the eye), or refractive errors. Early treatment will provide the best outcome, but vision lost from amblyopia will not return to normal.

---

### **Cataract**

Cataracts are damaged lens of the eye. They are clouded and prevent the normal amount of light from penetrating to the retina. Cataracts can appear at birth or any time afterward. Injury can cause the formation of a cataract. Early detection of cataracts is essential to allow the normal development of vision. The exam for cataracts is a critical part of the first few baby exams. It is very important to discover them early to allow the best chance for good vision. Cataracts are not common in infancy or childhood and there is no relationship to the cataracts found in older age groups.

---

### **Glaucoma**

Glaucoma is a condition where pressure inside the eye rises too high. Glaucoma can cause total blindness and requires early treatment. Warning signs include tearing, eye pain, and sensitivity to light. You might notice spasms of the eyelids, an enlarged eye or cloudy cornea. Glaucoma usually requires surgery to prevent blindness.

---

### **Tear duct**

The tear duct system is an important part of the eye's protective mechanism. It starts functioning fully within the first few months of life. For some infants, the process of opening is delayed up to 9 months. You might notice increased tearing in one or both eyes. Sometimes this excessive tearing can be a result of other medical conditions like glaucoma. If you notice continued tearing you should call the office for an appointment. You can try gentle massage near the eye to open the tear duct. I can show you a massage technique in the office. If massage and a reasonable waiting period are not followed by normal tearing, probing the tear duct could be necessary. Unfortunately, there is not much scientific evidence that the

massage is producing beneficial results. If necessary, I can refer you to the eye surgeon who will do the probing procedure.

---

**Ptosis**

Ptosis or drooping eyelids is a description of eyelids that don't open completely. This is caused by muscle weakness in the eyelids. If there is a mild degree of weakness no serious problems occur and no treatment is required. In some situations the weakness is so severe it interferes with normal vision. If the ptosis is present in infancy, it is essential that it is corrected promptly so that normal vision develops. When the weakness is severe, surgery is required to repair it.

---

**Blepharitis**

Swollen eyelids or blepharitis is an inflammation in the oil glands of the eyelid. You will notice swollen eyelids and crusting of the eyelashes. This is most common in the morning. The eyelids might also be tender and cause a feeling of something in the eye. Blepharitis is usually treated with warm compresses. If an infection develops antibiotics might be necessary. If you notice this condition you should call the office for an exam.

---

**Conjunctivitis**

Conjunctivitis or "pink eye" will be noticed as a reddening in the white part of the eye. You will notice excessive tearing, a pussy discharge, a feeling of something in the eye, or itching. Conjunctivitis can happen at any age and at any time of the year. For most children it is caused by a viral or bacterial infection. It can also be caused by an allergy or an irritation from chemicals or smoke. Depending on the cause of conjunctivitis I might treat the eye with eye drops or ointment. Usually eye discharge that is yellow or green are most likely to be helped by antibiotics. Good hand washing helps prevent the spread of the infection to other members of the family or friends. If the conjunctivitis is in a preteen or teenage girl and eye makeup is used, consider the makeup contaminated and toss it away and don't restart makeup until the infection is gone – about five days. If there are questions about whether there is conjunctivitis we will make an appointment to see your child or refer you to an after hours clinic if it is a weekend or night time need.

---

**Corneal abrasions**

Corneal abrasions or scratched cornea occurs when the outermost layer or surface of the eye is injured. These scratches of the eye cause tearing and sometimes severe pain. The most common treatment is patching of the eye. I might also prescribe antibiotics or topical pain relievers. I can often diagnose and treatment these injuries, but on the first exam I will determine if the injury requires consultation with an eye specialist or ophthalmologist. I do not treat eye infections without an office visit.

---

**Myopia**

Nearsightedness or myopia is common in children and makes it difficult to see objects clearly when they are far away. This condition is rare in infants and toddlers, but is much more common as children approach school age. Eyes can correct the vision problem but they will not cure the condition. The condition will usually progress through the teen-years, so I recommend yearly vision screening. I am able to pick up the risk for nearsightedness in the office and will refer you to an optometrist or ophthalmologist for corrective lens if needed.

---

**Hyperopia**

Farsightedness or hyperopia is normal in most infants and children. Mild degrees do not require correction and only should be monitored if the eyes are crossing or visual difficulties become excessive. This condition can be corrected with corrective glasses.

---

**Astigmatism**

Astigmatism is a condition where the cornea is irregularly shaped. It can cause blurring of vision and might require glasses for correction.

---

**Swimmer's ear**

During the summer months, each day I see several infections of the ear canal called swimmer's ear. "All that swimming, my kids are in the water all day", according to many parents. Children and adolescents don't have many cold-like symptoms, but it really hurts to touch their ear(s). On exam, I notice a pain ear during the exam. It is hard to look into the ear canal without the child jumping off the table. The ear canal itself is swollen and red.

The normal child's ear canal is protected with flaky skin and wax. After exposure to high humidity or moisture the canal can easily be invaded by opportunistic bacteria or fungi. The natural lining of the canal is acidic and will prohibit growth of bacteria but this becomes neutralized with constant water in the canal. After my exam, treatment consists of topical antibiotics and steroids to reduce the swelling and growth of the bacteria. Treatment lasts about five days but could last longer depending on the severity of the infection and the consistency of treatment.

With the warm the Fresno and Clovis weather, some families have their children in at least once each summer. It doesn't have to be so. After swimming, get the water out of the ear. I recommend a hair dryer on the lowest setting for several minutes in each ear. This usually works. Avoid touching or scratching the ear. Scratching increases the chances of introducing bacteria into the inflamed and swollen canal. Children with a history of wax build up or foreign material build up in the ears should be irrigated with warm water periodically. 20 cc syringes can be found at all pharmacies. Use the silicon type ear plugs to reduce the amount of water entering the canal. For those kids who lose the ear plugs, consider using a tight-fitting swim cap or wet suit hoods. Most over the counter ear drops for swimmers ear don't work well. You should look for drying agents for the ear. You can ask your pharmacist. These drying agents should not be used if there is any pain or tenderness in the ear at the time.

I don't treat swimmers ear infections over the phone. A surprising number of children have infections of the middle ear (otitis media) along with the canal (otitis externa). By treating over the phone I might under treat a more serious infection or miss fluid which can later interfere with hearing. The treatment is not the same. An oral antibiotic is used with common ear infection whereas a topical antibiotic is used with ear canal infections.

*Last reviewed May 15, 2007*

---

**Nose bleeds  
or epistaxis**

Nose bleeds are common in childhood. Bleeding can panic your child and the appearance of blood can be frightening to you. Stay calm and try to be reassuring because your anxiety can aggravate the situation. Nose bleeds usually stop in minutes without treatment. The amount of blood will not affect your child's health because the volume of blood is so small and it is quickly replaced.

Have your child sit straight and tip the chin downward. Pinch the soft end of the nose firmly for about five minutes continuously. If the bleeding persists, you may be pinching the wrong part. Reposition your fingers and repeat this up to two times or a total of 15 minutes. If the bleeding still persists, it may be necessary to seek more intensive treatment in the emergency room or with an ear-nose-throat (ENT) doctor. I can direct you or you can head right to the emergency room. Do not apply ice to the forehead or have your child lay on his or her back. Blood draining into the stomach can be irritating to the stomach lining and cause nausea or vomiting later.

Most nose bleeds are caused by intentional scratching or picking the nose. Asking your child to admit this is fruitless. Bleeding on the pillow at night occurs when your child does this while sleeping. To reduce this, cold medications can reduce the build up of mucus and reduce allergic itching. Humidifying the air helps too. Soften the outer nasal passages with Vaseline™.

---

**Styes and  
chalazion**

Styes are infections of the glands along edges of the lids of the eye. These small abscesses appear like red, tender bumps. They grow quickly and within a few hours or a day, they are full size. Chalazion is a condition commonly confused with a sty. It is a bump within the lid not usually along its edge and grows slowly over weeks or months. A

Chalazion is a fluid filled cyst. Styes are a bacterial infection and a chalazion is probably the result of an irritation or defect in the lid. Chalazions are treated and removed by an eye surgeon. While I can advise you how to treat a sty, if you aren't sure which you have, you can treat it as a sty without harming the eye.

Treat styes by applying warm compresses for 5 to 10 minutes 3 or 4 times a day. The warmth allows the infection to form a tip which will drain. The drainage does not usually require any antibiotics. Antibiotics will be of little benefit in most situations. If the sty does not improve after a couple of days, call my office for an appointment so I can determine the nature of the condition.

---

### **Blocked tear duct**

Your child's eyes need to be clean and protected from fine materials that may lodge in them. In infancy, the natural drain for tears may not be well developed or it may even be totally blocked. In most cases, you will clearly see tears flowing from one or both eyes without any obvious cause. In time this blockage will open without any special treatment.

In the past I recommended a circular massage, applying even pressure at the space between the bridge of the nose and the inner corner of the eye. The massage lasts for about a minute, four times a day. Within weeks the tearing decreases or disappears. Some believe there is little benefit from the massage, but I have not seen any harm from this simple action.

Some children develop secondary eye infections without any obvious cause or following a common cold or sinus infection. These infections often require antibiotic drops and this is done at the office visit. If there is no improvement by six to 9 months of age, I recommend a second opinion from an eye specialist. The ophthalmologist will determine if surgical probing is necessary to open the blocked tear or lacrimal duct.

---

### **Canker Sores**

Canker sores are painful recurrent ulcers of the mouth which appear on the lips, gums, inner cheeks, tongue, palate and throat. They are as small, shallow depressions in the lining of the mouth with sharp borders covered by a gray membrane and surrounded by a intense red halo. Tingling and burning sometimes precedes them by a day. During the first two to three days, canker sores are painful and can interfere with eating and drinking. Most sores heal without scarring within two weeks.

The cause of canker sores is not known but stress appears to be a contributing factor. Cankers don't look quite like fever blisters and their treatment differs too. I suspect a viral cause will be found in the future.

Because of an accompanying pain a child may not drink or eat normally. It is important to maintain a good intake of liquids, but citrus or salty foods will irritate the sores. I occasionally prescribe or recommend local pain relievers. Speak to your dentist too. Dentists deal with the mouth and these are common problems dentists feel comfortable treating. Orabase™ works well but is not tolerated by young children because it feels gritty.

A similarity with fever blisters is the recurrence rate for both. Most people have canker sores more than once. If you notice a fever, bad odor or facial swelling, please call the office because a secondary infection can be present.

## Adolescent Problems

### Adolescent females

Pediatricians do not see adolescents as often as children under five years. When I do see female adolescents, certain questions commonly come up. One of the most frequently asked questions relates to the puberty. When will she have her first period? She has too few or too many menstrual periods. How do I know she is normal?

These questions are very important to parents and for their adolescents. This is a major milestone in a young women's development and misinformation can lead to all types of problems.

During late childhood, important chemicals originating from the brain are released. These stimulate the ovaries to produce additional, essential chemicals like progesterones and estrogens. The first physical signs of puberty are breast budding. This appears around 11 years of age in about 85% of girls, but can be present as early as 8 or as late as 13 years. The appearance of public hair follows, although it may be the first sign of puberty for 15%- 20% of adolescents.

The estrogen release I mentioned earlier will change the character of the vagina and a thin, colorless, odorless fluid or discharge will precede the actual start of menstrual periods. This start of the menstrual cycle is called the menarche. Concern about this discharge is common. You can expect the menarche with menses in about 6 to 12 months following this early sign.

Menarche follows the breast budding or pubic hair of early puberty and will occur by about 12 to 16 years of age. Family history is very important. The date of onset of puberty of the mother corresponds to within one year of the age when puberty will begin for her daughter. In other words, the age when mom started her puberty is an accurate predictor of the age of puberty of her daughter.

During the first 6 to 12 months after menses begins, no egg is shed from the ovary. Because of this, it is common to notice that the periods are very irregular. Some girls may only experience one or two periods the first year while other girls will have regular monthly periods. If there has been no period by the age of 16 then I recommend a thorough evaluation by a pediatric endocrinologist or a gynecologist.

*Last reviewed May 18, 2007*

---

### Dysmenorrhea and premenstrual syndrome

Primary dysmenorrhea is the most common adolescent gynecological complaint. It is a painful period without any disease of the pelvis or obvious cause. Usually the first signs of dysmenorrhea appear with the first few periods.

Secondary dysmenorrhea is caused

by some disease process and appears after a regular ovulatory cycle or cycles. Secondary dysmenorrhea follows a long period of painless menses. Conditions that contribute to this dysmenorrhea are infections like pelvic inflammatory disease, complications of pregnancy, endometriosis or uterine or vaginal congenital conditions which cause blockage or adhesions.

At least 60% of adolescent females have menstrual pain. Half of these women have moderate or severe pain and 1/8th of all painful periods contribute to missed days of school and work.

*Special points:*

Other conditions can mimic painful periods or dysmenorrhea such as tumors, spontaneous abortions, pelvic infections, inflammatory bowel disease, and urinary tract infections. You should contact my office if the cramps don't get better and interfere with activities. The period should not last more than 10 days. If the flow is very heavy requiring more than 6 pads a day, this is abnormal. Be concerned if one period is missed after they were regular and you believe pregnancy is possible. She should see a doctor if she becomes sexually active or she believes she could have any sexually transmitted diseases.

Adolescents can get relief with over the counter pain relievers like ibuprofen (Advil™), aspirin or Tylenol™. Regular exercise and heat applied to the lower abdomen do help and should be tried. For those with moderate to severe pain, nonsteroidal anti-inflammatory drugs help about 75% of the time. For those who are helped little by this treatment, a pelvic exam is recommended. I refer to a gynecologist if that is necessary.

Oral contraceptives are used in some cases, especially sexually active adolescents. This method reduces pain by stopping ovulation and reducing endometrial growth.

---

## Problems with the penis

Skin oils and secretions often accumulate under the skin of the uncircumcised penis. This may accumulate and irritate the surrounding skin and lead to an infection. The skin can swell, turn red and interfere with the normal flow of urine.

If you notice the foreskin actually balloon, filling with urine, then medical attention is necessary. Urinary tract infections are more likely to occur.

If the foreskin can easily be retracted, a regular program of hygiene will decrease the chances of secondary infections. If you can not easily retract the foreskin, then no attempt should be made. The majority of children will have no difficulty retracting the foreskin after three or 4 years of age. If there is still difficulty retracting the skin do not attempt it because it will eventually loosen enough as the child grows older so that cleaning the area is easier. Return the foreskin to its normal position over the head of the penis. Sometimes the foreskin is so tight it cannot be pulled back. This is a problem and you should get my help if I am in my office or go directly to the Children's emergency room. The blood supply to the end of the penis can become impaired. This is not only painful but could cause permanent damage to the tip of the penis.

Discharges from the urinary opening are rare before adolescence and require attention at any age. If there is a build up of natural oils it may appear as an infection. Some occasions occur where an infection develops and drainage is necessary. Soaking the area in a warm water bath often enables the child or parent loosen the foreskin, permitting drainage of the oils or a minor infection. If this can not be accomplished I encourage you to seek my consultation.

A common problem with boys is getting the foreskin caught in the zipper. The child is often a 3 to 6 year old. This occurs most often when parents are in a hurry and zip up a younger child. One of the potential calamities of not wearing underwear, adolescents start wearing jeans with buttons or religiously wear underwear if this happens to them. Removal of the zipper can be achieved with one of these methods: soak the zipper and foreskin with mineral oil for 10 minutes then gently pull the foreskin free. If you have a heavy metal cutter you can split the medial bar of the zipper mechanism that will cause the zipper to fall apart and free the foreskin.

Last reviewed May 18, 2007

---

## Menstrual problems

New parents are sometimes shocked to find blood coming from the vagina of their week-old infant. This bleeding is caused by hormonal stimulation of the baby's uterus by the mother's hormones after pregnancy. When a baby is born, she is no longer exposed to these hormones and a small menstrual flow occurs. This is the same situation that will occur in adolescence when she enters her puberty. Do not be concerned if you see a small amount of vaginal bleeding in the first two weeks of life.

The normal time for your daughter's first menstrual period is quite variable. Nine to 16 years of age is the range I consider the normal. I encourage you to contact our office if a period begins earlier. After periods begin, cycles are seldom regular for the first two years. The amount of flow may vary widely. These variations usually last for several years after menarche or the beginning of menstruation. Medical help may be needed if the periods are very heavy, painful, prolonged, frequent or have stopped for more than 4 months.

Young women who have had regular periods for several years may have occasional missed periods. An emotionally upsetting experience, severe exercise or pregnancy are frequently the cause. Severe dieting may also affect the regularity of menstrual periods.

Approximately 15% of all women experience some premenstrual symptoms. These symptoms can include headache, irritability, abdominal bloating, breast tenderness, and thirst.

Five percent of women can have severe pain during menstruation. Crampy, lower abdominal or back pains begin shortly before the cycle and last about 24 hours. Over-the-counter medications including Tylenol™ or Advil™ work well in most cases.

Sexually active adolescents should have yearly physical exams which include a vaginal and Pap exam. Because I do these infrequently I would advise a visit with a gynecologist.

---

### **Vaginal discharge**

Prepubertal and pubertal girls have vaginal discharges that are normal. This discharge is white or slightly yellow without other symptoms. Adult hormones cause increased amounts of discharge. Discharges are also common during the first few weeks of life or in mid-cycle after the onset of menses.

Poor hygiene may contribute to vaginal discharge in children. Infestations of pinworms that migrated to the vagina may result in vaginal discharge after intense irritation or secondary infections occur. Another cause of discharges are yeast or candidal infections. These infections commonly occur while a child is on antibiotics.

*Last reviewed May 18, 2007*

## **Development and Behavior**

### **Toilet training your child**

There are many ways to toilet train your child. Here are some ideas which might be helpful when you decide to try. A potty chair can be given to your child sometime after he or she is 18 months old. The similarity between the parent's chair and the child's chair is then pointed out repeatedly.

Each day at the same time, take the child to sit on the potty chair. The first few times, leave the child's clothes on so the chair does not seem cold. Stay with your child, talking or reading a story. If your child wants to get off the chair, permission should be given.

After your child seems to be cooperating with the first part of the training, continue the daily trips without the diaper. As your child's interest grows, make a second trip each day, ideally after a diaper is soiled. Change your child on the chair and drop the soiled diaper in the chair. Then remind your child how to use the chair.

When your child understands and cooperates willingly, he or she will eventually, use the chair to urinate or have a bowel movement. At that point take your child to the potty chair several times a day to catch his or her urine or stool. If your child loses interest, you will need to go back to an earlier step in the training process. When your child loses complete interest, stop the whole process and restart at a later date.

Do not start your child too early, around 18 months is average, but it may be nearly two years before some are ready. Watch for signs of readiness. Many children appear uncomfortable after soiling their diaper and may even tell you. If your child becomes fearful or resistive, don't force the issue. Do not spank or scold your child for lapses. Anger and irritation could make your child more resistive and increase guilt feelings. Praise your child for using the potty.

Training panties may be helpful and make your child more aware of bowel and bladder function. Modern diapers are so absorbent, your child may not even be aware of urine or be uncomfortable. If none of the above works, don't worry because most children toilet train themselves between 2½ to 3 years. Many normal children wet their beds at night until they are six or older.

---

### **Does your child stutter?**

Many children repeat words and phrases or mispronounce words as they learn to talk. Most of the time these difficulties disappear. These are not stuttering problems, but parents are often quite worried. When children are learning to speak they often repeat words and phrases.

You will notice this behavior in the 18 month to 5 year old. This repetition of words is called dysfluency or pseudostuttering. Normal dysfluency appears in 90% of children. The mind works so quickly the mouth can't keep up. I have noticed this in a few adults too. In most situations children will mature and the dysfluency will disappear in about three months.

Many children also have a problem pronouncing words too. Normal dysarthria and mispronunciation are terms used to describe incorrect pronunciation of words. This is not true stuttering. Sounds are substituted or left out making many words hard to identify. Normal dysarthria appears in about 30% of 1 to 4 year olds. The cause of this problem is often hereditary. Unlike normal dysfluency, normal dysarthria may last years with slow, gradual improvement as the child develops. For about 90% of children who have dysarthria speech becomes completely understandable by 4 years of age. By 5 or 6 years, 95% of children can speak clearly.

True stuttering which affects only 1% of children involves repetitions of sounds, syllables, words or phrases. You can also notice hesitations and pauses in speech, absence of smooth

speech flow and fear of talking. Boys are four times as likely to stutter as girls. In situations of stress, fatigue or excitement stuttering appears more frequently.

In most cases true stuttering develops when a child with normal dysfluency or dysarthria is pressured to improve and in the process becomes aware of his inadequacies. Soon the child begins to anticipate speaking poorly and struggles to correct it. The child becomes tense when he speaks and the more he tries to control his speech the worse it gets. Hereditary factors play a role in stuttering. A speech pathologist or therapist plays an important role too in the treatment of stuttering and they should be consulted if a problems appears.

Parents need to encourage conversation with their children. Sit down and talk with your child. Keep the subject matter pleasant and interesting. Avoid asking the child to recite or perform verbally. Keep speaking time low-key.

Don't correct your child's speech. Avoid expressing disapproval. Avoid saying "Don't stutter" or "Think before you speak". This is your child's normal speech and is not controllable.

Avoid interrupting their and give them time to finish what they are trying to say. Don't complete their sentences and try to prevent their sisters and brothers from doing it too. Leave a few seconds between finishing their sentence and beginning yours.

Try not to force your child to repeat themselves or starting over. Listen closely and only ask them to repeat themselves unless it appears very important. Its OK to guess what they said sometimes rather than force them to repeat themselves. Don't ask them to repeat a certain sound or word. This just makes them feel more self conscious.

Don't ask your child to slow down. A rushed rate of speed is a temporary phase and can't be change by a parent's request. Model a relaxed rate of speech.

Don't label your child a stutterer. Labels tend to be self-fulfilling prophecies. Don't allow your children to mimic or tease the stutterer.

Ask other adults who spend time with your child to follow your examples as I have described them. Consistency sends the right message to your child.

When to seek help? If your child appears to stutter and is over 5 years old. If there are facial grimaces or tics. If your child is fearful or self-conscious about his speech. The family has a history of stuttering. If your child has said no words by 18 months or no sentences by 2½ years. If the speech is totally unintelligible by 2 years of age. If he is 3 years old and only half what he says is understandable.

*Last reviewed May 15, 2007*

---

## The first month

Babies cry a lot. During those periods when they are awake, they might cry as much as all their other active phases combined. Some days the baby can be quiet much of the day and on other days, there will be considerable crying, calmed by feeding, changing or holding.

Feeding is erratic too, with nursing lasting from 10 to 45 minutes on each breast. You will observe easy startling, hiccups, sneezes, and spitting up.

Most babies sleep restlessly. They are light sleepers and startle at the slightest noise. When you observe your baby sleeping, you will notice many expressions and noises. The baby can whimper, smile, frown, sneer and grimace. Most sleep periods are brief naps, and there are one or two longer deep sleep periods lasting around four hours.

---

## Motor activity

Most of the movements respond to stimulation as a reflex. The baby usually lies on his back with one arm flexed upward on the side he faces and the opposite arm at his side. He can not support his head well although he can pick it up and turn it when he lies on his stomach. He can not lift it long, but he can turn it long enough to clear his nostrils. If you pull him up he will support his head momentarily. He will keep his fists clenched, but will not hold objects placed in his hands. He will stare at objects, but does not try to reach them.

You can expect him to smile at your face or your voice. He will respond to your smile or voice with a smile. Sleep patterns and daytime waking periods are not consistent and change frequently.

Infants will feed about every three hours with two meals through the night. Bowel movements can vary from one every five days to one with every feeding. Your baby can gain ½ to 1 ounce of weight each day.

---

## **Two month old**

Things tend to start to settle down in the second month. Her feeding patterns are more regular or dependable. She might prefer a sleeping or feeding position, and object if this position is changed. Sleeping patterns can be predicted for most 2 month old infants. Many babies are sleeping through the night. Waking time during the day lengthens. She will be more inter-reactive and respond with cooing sounds or smiles.

Motor activity will increase. She is now able to hold her head up at an angle for several minutes. Her neck muscles are stronger so that she can keep her head erect with only slight bobbing. She will start to swing at things and hold them briefly.

Her attention increases with alertness to sounds. Her crying periods persist, but are more organized. She might cry near rest periods or before her night time sleep period. Crying often serves as a tension reliever. A certain amount of crying is important in this regard. I encourage you to allow your child to fuss or cry short periods up to 10 minutes at a time, because of the important role crying serves in normal development.

Mobiles are good at this age. If you place them about 10 inches away she will enjoy and follow them. She will get excited to see certain objects and will swing at them. She will anticipate feeding when a bottle is placed nearby or even at the sight of her mother who nurses her.

She enjoys other members of the family. She will quiet herself or become excited when seeing them. She will follow your face and move her head as you move yours. She will enjoy her bath.

She will eat less often at night and might sleep the night. Her bowel movements are less frequent and can become firmer or formed.

---

## **The third month**

Babies continue to improve socially. They are awake and increase their responses to you and their environment. They make more sounds and show many new expressions to reflect their mood. They have increased muscle strength, but continue to lie flat most of the time. Sleep patterns are more dependable. You can definitely predict the nap time and its length. His concentration is improving and you will notice him stare at objects for much longer periods. He recognizes sounds and shapes, and can quite distracted by familiar or unfamiliar sounds and objects. He will have much more purposeful use of his hands, striking at new objects or familiar sights. This is his first efforts at hand coordination.

This is a time you enjoy increased activity together with play, making faces and noises together. Your increased attention is rewarded with the warm responses from your baby.

Motor development changes from the reflexes controlling all his movements to more controlled body movement. You noticed when you picked him up a month or two earlier, his body was limp. Now when you pick him up, he tenses and coils up. His head strength is much improved too, and he will keep it elevated for many minutes while he looks around. When you pick him up, he will stiffen his legs as if he wishes to stand. I frequently am asked if you can cause bowlegs by let your baby stay in this standing position. The fact is that you can not cause bowlegs by allowing you baby to push upward and support his weight on his legs. When he is tired, he will relax his legs and sit or lie flat. He will sit now with less support and keep his head fairly erect. He swinging at objects now, but misses frequently. He will not grasp them effectively.

He will watch objects for up to an hour, following any movement from side to side. He also watches his own hands and feet attentively. It appears as if he is becoming aware of his hands and feet as part of himself.

He is very aware of persons, quieting at the sight or sound of a recognized person or persons. He will stop eating or sucking at the sound or sight of a familiar object or person. He will talk back to a familiar person or thing by making cooing sounds or chortling.

These are some of the many complex things babies do during the first 3 months of life. This is not a comprehensive listing, but there are many books at the local book stores that can aid you in determining if your baby is developing appropriately for their age.

*Last reviewed July 16, 2007*

## Hormones and Glands

### Thyroid

I wanted to speak about the thyroid because of its important role in growth. Many parents are concerned about their child's or adolescent's growth rate and development. It is one of my primary concerns when I review your child's growth chart and mental development.

The thyroid gland is located at the base of the neck and cradles the wind-pipe surrounding it. Its role in the body's chemical factory concerns important functions involving the rate which are body uses the basic building blocks of growth and how we control them. I do not want to go into detail how the thyroid functions but emphasize it has an important role. Because of this important role, how much or how little of the chemicals produced from the thyroid gland can influence how the child appears or the symptoms we see.

The mother's thyroid gland and how well it functions can influence the growth of the developing baby. The newborn screening that is mandatory for every baby born includes a test for thyroid function. When the infant's thyroid does not produce enough hormone, delayed mental and physical growth are delayed. We can treat the physical growth effectively, but in some cases the mental development is irreversibly damaged. It is this reason Pediatricians watch growth (mental and physical) so closely. The earlier I detect a problem and repair it, the better the chances for optimal development. In infants, poor muscle tone, slow growth, slow developmental maturation and other signs can indicate inadequate production of thyroid hormone. This can be replaced with medications. In older children and adolescents decreased energy, worsening grades, depression and other signs of decreased metabolism can indicate thyroid disorders. Weight gain alone is not a good indicator of slowed thyroid function. This is a common misconception by many parents and prompts them to request thyroid testing. In almost all cases this weight gain is due to eating more calories than necessary.

For some adolescents the thyroid may produce too much hormone causing weight loss, nervousness increased appetite. One type of thyroid found in the infant, child or adolescent can produce signs like those you noticed in Mrs. Barbara Bush (a past President's wife) with the look of starring with bulging eyes. This is treated by blocking the thyroid from releasing the hormone or destroying the gland itself and providing the hormone with medications.

The point I want to leave is that the thyroid provides an important role in the normal function of the body. Any sign of problems of a poorly functioning thyroid gland are watched and if necessary evaluated and treated.

---

### Premenstrual syndrome or PMS

This a group of feelings or physical changes that some adolescents and older women get about one week prior to their menses. You might notice any combination of these symptoms : increased acne, feeling tired, feeling bloated, increased appetite, weight gain, breast soreness, mood swings, headaches, constipation, and feeling irritable.

Suggestions for the relief of PMS symptoms. Please consider these ideas if you believe your adolescents symptoms sound like PMS syndrome. Keep track of the time of the month and the cycle of the periods. It will be easier to make sense of the strange feelings if you are aware it might be PMS causing the changes you are experiencing.

The next few suggestions are general and apply to many situations, but especially to PMS. Get enough rest but its important to establish a regular routine of exercise. Extra caffeine can cause a problem, plus dramatic changes in diet with extra sugar can aggravate the symptoms. Try to reduce stress at times when it is more difficult to deal with it.

---

### Hepatitis

This disease strikes terror in families because parents fear the worst outcome or have many misconceptions. Hepatitis is an inflammation of the liver. Most cases are not recognized because it is generally mild and symptoms are not severe. Its symptoms are nonspecific like

fever, headache, general achiness, loss of appetite or an itchy rash. After a few days, you will notice more nausea and vomiting, stomach ache and in some cases jaundice (yellowness of the whites of the eyes and skin). Urine will be dark and stools will change to a tan or white color. The area of skin over the liver can be quite tender from the swelling of the liver.

Viruses cause inflammation of the liver including the virus of mononucleosis ( Epstein-Barr virus ). Two recognized forms of hepatitis are infectious or “A” type and Serum or “B” type. Incubation period can vary from 1 month for infectious hepatitis to 6 months for serum hepatitis. Infectious hepatitis is spread from one person to another from intimate contact or from infected water or food. Serum hepatitis is spread by contact with contaminated blood which can occur when infected needles are used or shared.

There is no cure for the viral infection once it develops in the body. Treatment focuses on meeting the nutritional needs of the infected child. Foods should be lower in fats and contain only mild to moderate amounts of proteins. Carbohydrates are easier to digest than fats or proteins, but all food types can be eaten.

If a member of the family is known to have infectious hepatitis, all family members used to receive immune globulin to prevent or to minimize the severity of hepatitis. This is no longer available or advised. Once the disease is diagnosed, immune globulin will not stop the infected person’s disease. Some children and adults can have damage to the liver or a chronic hepatitis. It is important to prevent cases of hepatitis, whenever possible. Fortunately, there will be complete recovery from infectious hepatitis in more than 90% of children.

In the current recommendations for vaccines children right after birth may receive the first of three doses of hepatitis B vaccine. At age 1-2 years the hepatitis A vaccine can be given and the second of two doses can be completed in six to 18 months. Other types of hepatitis vaccines like C are not available at the time of this article (July 16, 2007)

## Immunizations and Vaccinations

Diphtheria, Tetanus, and Pertussis Vaccine (DPT)

What you need to know before your child gets the vaccine

### About the Disease

Diphtheria, tetanus (lockjaw), and pertussis (whooping cough) are serious diseases.

Diphtheria and pertussis spread when germs pass from an infected person to the nose or throat of others. Tetanus is caused by a germ that enters the body through a cut or wound.

<p><b>Diphtheria causes:</b> a thick coating in the nose, throat, or airway</p>	<p><b>Tetanus causes:</b> serious, painful spasms of all muscles</p>	<p><b>Pertussis causes:</b> coughing and choking for several weeks (makes it hard for infants to eat, drink, or breathe)</p>
<p><b>It can lead to:</b></p> <ul style="list-style-type: none"> <li>• breathing problems</li> <li>• heart failure</li> <li>• paralysis</li> <li>• death</li> </ul>	<p><b>It can lead to:</b></p> <ul style="list-style-type: none"> <li>• locking of the jaw so the patient cannot open his or her mouth or swallow</li> <li>• death</li> </ul>	<p><b>It can lead to:</b></p> <ul style="list-style-type: none"> <li>• pneumonia</li> <li>• seizures or convulsions</li> <li>• brain damage</li> <li>• death</li> </ul>

### About the Vaccines

#### Benefits of the vaccines

Vaccination is the best way to protect against diphtheria, tetanus, and pertussis. Because most children get the vaccines, there are now many fewer cases of these diseases. There would be many more cases if we stopped vaccinating children.

**DT<sub>a</sub>P schedule** Most children should have a total of five DPT vaccines.

They should have DPT at:

- 2 months of age
- 4 months of age
- 6 months of age
- 12-18 months of age
- 4-6 years of age

Related vaccines

DTaP (Diphtheria Tetanus acellular Pertussis)

Like DPT, it prevents diphtheria, tetanus, and pertussis

It is only given for the 4th and 5th doses

It is less likely to cause the mild problems we see after DPT and is probably less likely to cause some of the moderate problems

DT (Diphtheria Tetanus)

Unlike DPT, it does not prevent pertussis. For this reason, it is usually not recommended.

---

### Who should get DPT vaccine?

Most doctors recommend that almost all young children get DPT or DTaP vaccine.

Some child. should get DT With all vaccines, there are some cautions.

Tell your doctor or nurse if the child getting the vaccine:

ever had a serious allergic reaction or other problem after getting DPT, DTaP, or DT

- now has moderate or severe illness

- has ever had a seizure
- has a parent, brother, or sister who has had seizures
- has a brain problem that is getting worse

If you are not sure, ask the doctor or nurse

---

### What are the risks from DPT vaccines?

As with any medicine, there are very small risks that serious problems, even death, could occur after getting a vaccine.

The risks from the vaccine are much smaller than the risks from the diseases if people stopped using vaccine. Below is a list of problems that may occur after getting the vaccine. **If your child ever had one of the moderate or severe problems listed below or any other serious problem after DPT, DTaP, or DT**, discuss with the doctor or nurse before this vaccination.

---

### Mild DPT problems

If these problems occur, they usually start within hours to a day or two after the

vaccination. They usually last up to 1-2 days:

- soreness, redness, or swelling where the shot was given
- fever
- fussiness, drowsiness, less appetite

Acetaminophen or ibuprofen (non-aspirin) may be used to prevent or reduce fever or soreness. This is especially important for children who have had seizures or had a parent, brother, or sister who has had seizures.

---

### Moderate DPT problems

*Once for every 100-1,000 doses:*

- on-going crying for three hours or more
- fever of 105° or higher
- an unusual, high-pitched cry

*Once for every 1,750 doses*

a seizure or convulsion usually caused by a fever  
“shock-collapse”- (becomes limp, pale, and less alert)

---

### Severe DPT problems

*These problems happen very rarely:*

- serious allergic reaction after DT or DPT
- a long seizure
- decreased consciousness or coma.

Some of these children may have lasting brain damage. There is disagreement about whether DPT causes the lasting brain damage. If it does, it is very rare.

#### **What to do if there is a serious DPT reaction:**

Call a doctor or get the person to a doctor right away.

Write down what happened and the date and time it happened.

Ask your doctor, nurse, or health department to file a Vaccine Adverse Event Report form or call: (800) 822-7967 (toll-free)

The **National Vaccine Injury Compensation Program** gives compensation (payment) for persons thought to be injured by vaccines. For details call: (800) 338-2382 (toll-free)

If you want to learn more, ask your doctor or nurse. He or she can give you the vaccine package insert or suggest other sources of information.

---

### Pertussis or whooping

Pertussis is part of the DPT series of vaccine. This disease is still persistent in our community. Unlike other immunized diseases it persists in our environment and is has not been eliminated

---

**cough**

by vaccines. Most of the cases seen today are under immunized or unimmunized children and adults. This is one of the most contagious of the preventable diseases. It spreads through direct contact or by contact with infected particles spread by coughing.

The incubation period is 1 to 3 weeks. The disease will cause symptoms for up to three weeks. The illness starts as a simple cold with runny nose, cough, and fever. The initial illness last about one week and then the intensity of the cough increases. The cough is characteristic with as many as 5 to 10 coughs followed by a long breath inward producing the classic whoop. The cough is so severe the child's eyes bulge, face turns red, tongue sticks out and the veins of the neck protrude. Coughing can continue until the mucous plugs become dislodged from the small airways. Many children vomit. Coughing episodes are exhausting and can produce a great deal of fatigue. This intense coughing can last weeks. After this intense period of coughing passes, there is a less intense period of coughing that can last months.

Complications can include pneumonia, ear infections, convulsions, coma and death.

In the recent past, the Pertussis portion of the vaccine has incurred a great amount of notoriety. It was linked in the media with the possibility it might trigger Sudden Infant Death Syndrome. It has long been noted to be the main trigger for substantial fever, swelling and crying in 5% to 10% of the children receiving the vaccine. It is known to cause some side effects, but considerable research does not point to the vaccine or Pertussis as the cause of S.I.D.S. in infants. Doctors will exclude Pertussis as part of the vaccine if there is fever greater than 105°, shock, convulsions, or prolonged screaming appears after the vaccine is given. There does not appear to be any proven risk for S.I.D.S. and the risks of contracting Whooping cough and developing complications far outweigh the risks of side effects.

---

**Tetanus (lockjaw)**

Tetanus is a life threatening illness cause by a toxin (chemical produced by the *Clostridium tetani* bacteria). The incubation period is a few days to a couple of weeks. This disease can cause symptoms localized to one part of the body or a generalized infection. Lockjaw comes from observations of the child after contracting the illness. The infection produces a grimace or sardonic grin (the jaw appears locked in a strange smile). Many different muscle groups are effected with spasms of the back, arms, or legs. These spasms can last for seconds or minutes. They produce exhaustion and extreme pain. The upper airway can also go into spasm producing suffocation and death. There is also a form of the disease that is found in the newborn. Unhygienic birth conditions and lack of maternal immunizations appear to play an important role in this infection. Tetanus is one of the worst diseases I have ever seen because of the suffering it causes. Treatment is difficult and consists of support for the person until the disease run its course or the child dies.

---

**Hemophilus influenzae**

Hemophilus influenzae is a bacteria that causes many types of disabling and sometimes fatal illnesses. The HIB vaccine is given at 2, 4, 6 and 15 months and is a very effective deterrent to invasive H. Flu disease.

Most of the children infected are at greater risk for complications when they are very young (under 18 months). One complication is Hemophilus meningitis. This is one of the most common forms of meningitis in young children. Another complication is acute epiglottitis, an infection of the upper airway, infects the 2 to 7 year old child. Children with this condition have a rapid onset of symptoms including: difficulty to swallow, drooling and difficulty in breathing. If not recognized early, this infection becomes one of the true Pediatric emergencies. Children become sick and die in hours after their airway swells and can result in suffocation. Other infections caused by Hemophilus influenzae are pneumonia, infections of the joint, skin, bone and blood. This vaccine has the fewest side effects of the injectible vaccines and is given into the muscles of the thigh. Since the vaccine is commonly used infections are uncommon now.

---

**Polio**

Polio is a viral infection. Most infections with polio viruses cause generalized

symptoms including sore throat, body ache, fever, constipation, cough and runny nose. The illness does **not** progress into complications or paralysis in about 95% of those infected. The most serious form can cause varying degrees of paralysis. The paralysis can be localized or more generalized including paralysis of the breathing centers and supporting muscles. This disease occurs mainly in unimmunized children. The vaccine is composed of the three most common viral strains producing disease. The vaccine is made from live virus but is treated so that it can not reproduce and spread as the harmful virus can. The most common form of the vaccine was the Sabin or oral polio vaccine. It is not recommended for most children. In certain situations when the child is immunocompromised (immune system is damaged) other forms of the Polio vaccine can be considered. The Salk vaccine, made from killed virus, is the recommended vaccine in that case.

---

## Polio vaccine

### About the disease

Polio is a serious disease. It spreads when germs pass from an infected person to the mouths of others. Polio can:

- Paralyze a person (make arms and legs unable to move)
- Cause death

### About the vaccines

#### Benefits of the vaccines

Vaccination is the best way to protect against polio. Because most children get the polio vaccines, there are now very few cases of this disease. Before most children were vaccinated, there were thousands of cases of polio.

There are two kinds of polio vaccine

*OPV* or *Oral Polio Vaccine* is rarely given to children now. It is given by mouth as drops. It is easy to give and works well to stop the spread of polio.

*IPV* or *Inactivated Polio Vaccine* is given as a shot in the leg or arm. This vaccine is now the recommended route for immunization for the at least the first 2 vaccines in the series

---

## Who should get IPV?

Most doctors recommend that almost all young children get IPV. Tell your doctor or nurse if the person getting the vaccine or anyone else in close contact with the person getting the vaccine is less able to fight serious infections because of:

- a disease that he or she was born with
- treatment with drugs such as long-term steroids
- any kind of cancer
- cancer treatment with X-ray or drugs
- AIDS or HIV infection

If so, your doctor or nurse will probably give IPV instead of OPV. If you are older than 18 years, you usually do not need polio vaccine.

#### Travel

If you are traveling to a country where there is polio, you should get IPV.

#### Pregnancy

If protection is needed during pregnancy, IPV can be used.

#### Allergy to neomycin or streptomycin

Does the person getting the vaccine have an allergy to the drugs neomycin or streptomycin? If so he or she should get OPV, but not IPV. Ask your doctor or nurse if you are not sure.

Tell your doctor or nurse if the person getting the vaccine:

- ever had a serious allergic reaction or other problem after getting polio vaccine
- now has moderate or severe illness

If you are not sure, ask your doctor or nurse.

---

**What are the risks from polio vaccine?**

As with any medicine, there are very small risks that serious problems, even death, could occur after getting a vaccine. The risks from getting the vaccine are *much smaller* than the risks from the disease if people stopped using vaccine.  
 Almost all people who get polio vaccine have no problems from it.

---

**Risks from IPV**

This vaccine is not known to cause problems except mild soreness where the shot is given.

**What to do if there is a serious IPV reaction:**

Call a doctor or get the person to a doctor right away.  
 Write down what happened and the date and time it happened.  
 Ask your doctor, nurse or health department to file a Vaccine Adverse Event Report form or call: (800) 822-7967 (toll-free).

The **National Vaccine Injury Compensation Program** gives compensation (payment) to persons thought to be injured by vaccines. For details call: (800) 338-2382 (toll-free)

If you want to learn more, ask your doctor or nurse. She or he can give you the vaccine package insert or suggest sources of information.

*Last reviewed July 16, 2007*

---

**MMR vaccines**

**Benefits of the vaccines**

Vaccination is the best way to protect against measles, mumps, and rubella. Because most children get the MMR vaccines, there are now many fewer cases of these diseases. There could be many more cases if we stopped vaccinating children.

*MMR schedule*

Most children should have a total of 2 MMR vaccines. They should have MMR at:  
 12-15 months    4-6 years of age  
 of age

Other vaccines can be given at the same time as the MMR.

Who should get MMR vaccine?

Most doctors recommend that almost all young children get MMR vaccine. But there are some cautions. Tell your doctor or nurse if the person getting the vaccine is less able to fight serious infections because of:

Also:

People with AIDS or HIV infection should usually get MMR vaccine  
 Pregnant women should wait until after pregnancy for MMR vaccine  
 People with a serious allergy to eggs or the drug neomycin should tell the doctor nurse. If you are not sure, ask the doctor or nurse.

Tell your doctor or nurse if the person getting the vaccine:

- ever had a serious reaction or other problem after getting the MMR
- now has moderate or severe illness
- has ever had a seizure
- has a parent, brother, or sister who has had seizures
- has gotten immune globulin other blood products (such as a transfusion) during the past 3 months.

If you are not sure, ask your doctor or nurse.

What are the risks from MMR vaccine?

As with any medicine, there are very small risks that serious problems, even death, could occur after taking the vaccine.

The risks from the vaccine are *much smaller* than the risks from the diseases if people stopped using vaccine.

Almost all people who get MMR have no problems from it.

*Mild or moderate problems*

Soon after the vaccination, there may be soreness, redness, or swelling where the shot was given.

*1-2 weeks after the first dose, there may be:*

- rash (5-15 out of every 100 doses).
- Fever of 103° or higher (5-15 out of every 100 doses). This usually lasts 1-2 days.
- Swelling of the glands in the cheeks, neck, or under the jaw.
- A seizure usually caused by fever. This is rare.

*1-3 weeks after the first dose, there may be:*

pain, stiffness, or swelling in one or more joints up to three days (1 out of every 100 doses in children; up to 40 out of every 100 doses in young women). Rarely, pain or stiffness lasts a month or longer, or may come and go; this is most common in young and adult women.

Acetaminophen or ibuprofen may be used to reduce fever and soreness.

*Severe problems*

These problems happen very rarely:

- serious allergic reaction
- low number of platelets ( type of blood cell) that can lead to bleeding problems. This is almost always temporary.
- Long seizures, decreased consciousness, or coma

Problems following MMR are much less common after the second dose.

*What to do if there is a serious reaction:*

Call a doctor or get the person to a doctor right away.

Write down what happened and the date and time it happened.

Ask your doctor, nurse or health department to file a Vaccine Adverse Event Report form or call: (800) 822-7967 (toll-free).

The National Vaccine Injury Compensation Program gives compensation (payment) to persons thought to be injured by vaccines. For details call: (800) 338-2382 (toll-free)

If you want to learn more, ask your doctor or nurse. She or he can give you the vaccine package insert or suggest sources of information.

**MMR** is a combined vaccine including Measles, Mumps and Rubella (German Measles).

**Measles** or Rubeola is a contagious viral illness common throughout the world. Its incubation period lasts about 1 to 2 weeks. After symptoms develop the child shows signs of a runny nose, red eyes and mild to moderate fever (101° to 102°). As the disease progresses, the cough becomes more severe and the fever increases to 104° to 105°. A red, flat rash appears around the ears, neck and hairline. The gland of the neck may be swollen and the rash can be itchy.

Complications of measles are pneumonia, with possible involvement of the heart and nervous system. Viral measles' pneumonia can be fatal. There is no treatment for the disease but bacterial, secondary infections can be treated with antibiotics. Immunizations of this disease are effective but after the first dose of vaccine at 12 to 15 months, a second dose of the combined vaccine is given around the age of 5 years. It is injected into the muscles of the thigh.

**Mumps** is another contagious illness caused by a virus. It causes various symptoms but the primary symptom is swelling of the primary salivary gland called the parotid gland that is located in front of the ears. There are many secondary infections that can appear after an infection of the mumps virus. Infection of the coverings of the brain and spinal column is the most common secondary infection. Other secondary infections include infections of the testes in boys or the ovaries in girls. Also there can be infections of the pancreas, kidneys, thyroid, heart or ears (deafness). Mumps can cause many problems and is a disease that warrants immunization so that we can prevent complications.

**Rubella or German Measles** is part of the MMR vaccine too. It is a contagious illness as the rest of the diseases I mention in the manual. The incubation period is 2 to 3 weeks. The disease starts as mild cold-like illness with runny nose or sore throat. Remarkable swelling of the glands of the neck is noticed especially behind the ears, neck and head. The rash is a flat red rash starting on the face and spreading outward to the chest and then the extremities. It may fade on the face where it first appears as it appears on other areas of the body. The

disease is not serious in the child and complications are unusual. Arthritis has been reported in women, and conditions resembling chronic fatigue syndrome have been described. The complications occur in the pregnant unimmunized mother who contracts the disease. Birth defects do appear with complications such as mental retardation, cataracts, bone damage, heart, liver and kidney disease.

---

**Hepatitis B vaccine**

The Immunization Practices Committee of the U.S. Public Health Service and the American Academy of Pediatrics Committee on Infectious Diseases recommends all infants in the United States be immunized for Hepatitis B.

Ten to 15% of cases of Hepatitis B occur in children. Most cases are recognized because of increased perinatal screening. The population we serve has changed. Many mothers risk contracting Hepatitis B, because they are IV drug users. There is an influx of South East Asians who are Hepatitis B carriers, but Alaskan and Pacific Islanders are also noted to be carriers. Ninety percent of babies who are born from Hepatitis B carriers will become carriers. 25% of these children will develop serious disease, such as chronic hepatitis or liver cancer. Also, children in child care areas where are there Hepatitis B carrier children have an increased risk of developing Hepatitis B or becoming carriers.

There is a larger problem for the population in general. Efforts at targeting high-risk adults by immunizing them has failed. At least two major problems stand in the way of accomplishing this goal. First, there are three possible schedules for introducing the vaccine. Second, the cost of receiving the vaccine is great. The Centers for Disease Control has a goal of integrating the vaccine with the standard vaccines currently given.

The political environment is bright for governmental support of such a universal campaign. Legislators have been sensitized about the issues of Hepatitis B along with current concerns for HIV infected individuals. One important group to be targeted with a campaign for immunization is the adolescent population. About 10% of the cases of Hepatitis B are seen in adolescents. It is believed most of these were sexually transmitted.

The recommendation proposed will be to combine the vaccine with the currently recommended DPT vaccines at 2, 4, and 6 months. Although two alternate schedules are mentioned - 2, 4 and 15 months or birth, 2 and 15 months. A universal immunization program instituted in Alaska and Pacific Island populations proved very successful. There was a 99% drop in acute cases among infants, children, and adults.

---

**Chicken pox vaccine**

Although Chicken Pox is rarely fatal to children or adults, the price for families is great. Two thirds of families have both parents working. Children or adolescents are forced out of classroom or child care. This situation requires adult to miss work for at least one week. Many children develop secondary complications like ear, sinus, or chest infections. A doctor's appointment and antibiotics can be necessary. There is treatment for the viral infection with a safe antiviral medication but the results can be minimal. It is most effective if given in the first 24 hours of the eruption of the pox lesions. I don't commonly prescribe the medication because the results are unpredictable.

More serious complications can involve the eye or brain. The vaccine can be given as early as 1 year of age.

---

**Immunization schedule**

This is the standard schedule for immunizations. Children who have missed vaccines or have medical conditions may need to follow a different schedule.

- Birth: Hepatitis B up to 2 month old
- 2 months : DPTa/DT, HIB and Polio(IPV), Hepatitis B, Pneumococcal vaccine
- 4 months : DPTa/DT, HIB and Polio (IPV), Pneumococcal vaccine
- 6 months : DPTa/DT, HIB, Pneumococcal vaccine
- 9 months :

12 months: Measles/Mumps/Rubella, PPD skin test, Chicken Pox, Pneumococcal vaccine

15-18 months: DPTa/DT and HIB

2 year Hepatitis A repeat in 6 to 18 months

5 years : MMR booster, DPTa and IPV booster

11-15 years : Tetanus booster is given every 10 years, Hepatitis B series

A MMR booster should be given to those born after Jan. 1, 1957 or later if they have had one MMR or if they have not had a doctor's confirmation of Measles.

The vaccine for meningococcal vaccine called Menactra was released 2005. Our office plans to carry this vaccine in the future. You can contact the office for more information.

*Last reviewed July 16, 2007*

## Infections and Contagious Illnesses

### Fever

A fever is a temperature of 101° degrees or greater taken oral, rectal or axillary route. Fever is often an indication of an impending illness. **Fever in children is not an emergency. Fever in children is not an emergency.** I know I repeated myself, because it is the most common reason people call day or night. Relax and read on.

Most fever is *good fever* (<103°) and helps the body fight infection. *You don't have to treat it with fever lowering medicines.* I believe that your child should feel comfortable and you can use Tylenol™ or other fever lowering medication if you wish.

Take your child's temperature if you suspect a fever because it confirms your suspicion and assists me in diagnosing and recommending treatment over the phone. Try to take your child's temperature before calling my office if you suspect a fever or have questions about an illness.

Call right away if:

1. You have an infant 6 weeks old or less.
- or 2. Temperature is 105° or greater 30 minutes to 1 hour after fever lowering medications were given.
- or 3. Your child appears very pale and is unaware of the surroundings.

\*Remember, most illnesses may begin with some fever, so 24 to 48 hours of fever is common. **Don't be alarmed.** Children can tolerate fevers to 105° degrees for hours. If the fever persists past 1 to 2 days or the illness appears much worse — please, call the office.

*Last reviewed May 15, 2007*

---

### Fever Treatment

Take off any unnecessary clothing. Give acetaminophen (Tylenol™) or other fever lowering medication,

by mouth or if there has been vomiting Febernol™ by suppository every 4 hours as necessary. Giving Tylenol™ more frequently or dividing the doses will not help and could be dangerous. Ibuprofen may be given at a dose of about 10 mg per 20 pounds up to a maximum of 400 mg. These anti-inflammatory medications are also good for many injuries.

For young children and adolescents whose fevers are not lowered and who are still quite uncomfortable, try a tepid water bath. As the water temperature cools, the body temperature should be lowered. This works well but is not long lasting in its effects. There is little benefit to bathing for mild temperature elevations. You can sponge bath by letting your child sit in a few inches of lukewarm water. Let your child play or relax while you run water over him or her. Check the temperature every thirty minutes or until you are able to lower it a couple of degrees or your child perks up and appears more comfortable. Give your child cool things to drink like soft drinks, water, juices, or popsicles.

Don't let your child get chilled. Don't use ice water or alcohol. A screaming, kicking, or shivering child won't cool off. Try to get your child to play or sleep. Children, even with mild illnesses, may be irritable, lack energy, sleepy, have a poor appetite, or appear dazed or glassy eyed. I only become alarmed if the child is not aware of the parent.

---

### Coughs and Colds

Most colds go away by themselves, sometimes in just a few days. Commonly, colds will last from 7 to 10 days. At the present time, there are no medications to cure a cold. Penicillin and other antibiotics have absolutely no effect on a common cold. If your doctor gave you an antibiotic for your cold, he or she probably suspected a secondary infection was also involved. Some doctors may succumb to parent's requests for treatment even though there is no recognized infection associated with a viral cold. If you believe your

child has a cold and develops these symptoms, I encourage you to call our office for a brief exam.

1. Fever of 101° or more for 2 or 3 days.
- or 2. Persistent pain.
- or 3. Vomiting for more than 8 to 12 hours without successful fluid intake.
- or 4. Very pale and unresponsive to the surroundings.

If a baby's nose is full of mucus, the mucus can be removed with a bulb syringe. If the mucus is too thick to suction easily, salt water drops sprayed or dropped into the nostrils just prior to suctioning will help greatly. Do not use Q-tips™ to clean the nose or ears by probing inward beyond your vision. You may pack the mucus or wax so deeply that you will cause greater problems. A tickle in the throat can be helped by a mixture of lemon and honey for children over one year only. Honey given to infants under one year has caused a life threatening illness called Botulism. Extra fluids seem to help all persons who have cold symptoms. Use fluids as your child tolerates them, but do not force fluids. Laxatives do not shorten a cold and are not recommended.

Frequent colds do not have anything to do with tonsils and adenoids. Tonsils play an important role in the body's defenses against infections. Tonsils are naturally large during school-age years when they are exposed to many infections. Very few children need to have their tonsils or adenoids removed. Tonsils should only be removed when they interfere with normal breathing, sleep, or produce persistent snoring.

---

### **Croup**

If your child awakens with a harsh "barking" cough, you should moisten the surrounding air with a "cool mist" vaporizer. Air in the room should be as moist as possible. If you do not have a vaporizer or humidifier, running the shower in the bathroom is a good way to produce steam quickly. You should stay with your toddler and let him or her breathe the steam but do not put them in the hot water. If there is no improvement and there is difficulty in breathing take your child to Children's emergency room for assessment and treatment. Notify me the day after this cough begins because I may be able to shorten the illness and reduce its severity by prescribing a special.

---

### **Head lice**

Head lice are very common. School age children can get lice from school friends, neighbors or relatives. These are nuisance pests rather than serious health problems. They usually cause severe itching of the scalp and neck. They are transferred from person to person by direct contact or by sharing brushes or combs. They can only live for a few hours when removed from the human body. Over-the-counter preparations are effective. Nix Cream Rinse and some other treatments are over-the-counter and recommended for killing eggs and adult lice. You may have difficulty differentiating the eggs (nits) from dandruff. If the problem persists or you are not sure if your child has lice, call my office for an appointment.

---

### **Chicken pox**

This is a viral infection that is quite contagious from one to two days before the rash erupts until all the rash has scabbed. The rash starts as a red blotch that becomes raised and quickly forms a clear blister at its center. The blister quickly ruptures and then scabs. The rash appears in groups called "crops." Fever is usually present in the earliest stages of the illness. Fever that occurs later in the illness may indicate the start of a secondary bacterial illness that needs my attention. Itching may be intense the first few days of blistering rash. Calamine™ or Caladryl™ lotions may help reduce the itching. Baking soda baths are useful to reduce the itching too. I often recommend Benadryl™ or other over-the-counter antihistamine prescriptions to control the itching. The illness last 7 to 10 days. One infection usually establishes lifelong immunity, but repeat cases are possible.

---

### **Pink eye or Conjunctivitis**

Redness, irritation and pussy discharge can be caused by a virus, bacteria or allergy. I usually start treatment with an antibiotic drop assuming it is a bacterial infection.

If there is a clear discharge then it might just be an irritation or allergy that won't be a likely to be helped with antibiotics. You will need an appointment so that I can determine a likely cause of the eye inflammation. It may be necessary to refer to an eye specialist (ophthalmologist). Itchy, red eyes with hayfever symptoms may be relieved with non-prescription allergy eye drops like Visine™.

---

### **Bladder or urine infections**

Urinary tract infections or bladder infections are common in childhood and adolescence. Symptoms in later childhood may be easy to spot but very confusing in the infant. Symptoms are : burning or pain while urinating, urgency or frequency in urinating, and back pain or fever, although back pain or fever are uncommon. These last symptoms may warn of kidney infections.

For infants, other symptoms may include : weight loss, vomiting, diarrhea, nausea, failure to gain weight or even jaundice. In early infancy, boys are three times more likely to have a urinary tract infection. This infection is carried to the bladder or kidneys from the blood. In childhood, bedwetting in a previously dry child, or abdominal pain may indicate a bladder infection. Treatment with any of several antibiotics works well. After treatment, I may suggest a follow-up test of the urine to insure no new infection has appeared.

---

### **Bacteria vs. virus**

Many parents are naturally confused about bacterial and viral illnesses. It is important to understand the difference between these two words because my treatment plan will be based on the type of infection I suspect.

Bacterial infections cause illnesses like : strep throat, ear infections, skin infections such as impetigo, pneumonia or meningitis. Each infection can range from less serious to life threatening. Although some bacterial infections will go away on their own, with the use of drugs like antibiotics, recovery is quicker and complications are reduced. For this reason, I use various methods (lab tests, physical examination, and your child's history) to determine if your child could have a bacterial infection.

The use of antibiotics should not be taken lightly. Some children suffer reactions to antibiotics. While most side effects are annoying at worst, severe allergic reactions can be life threatening. Let me know if your child has allergies to any medications.

If I suggest and prescribe antibiotics it is critical that your child take them for the length of time I indicate.

Viral infections are extremely common. Most of us will get several viral infections every year. The average child has 5 to 10 illnesses each year. Symptoms of viral illnesses can mimic bacterial illnesses. It can be difficult to separate and determine which infection your child has. Yet, viruses are less likely to cause serious complications.

Viruses are not affected by antibiotics. Certain medications can help some viral illnesses and several drugs are able to control and even kill some viruses. Even though most viral illnesses must run their course, I will probably be able to substantially reduce unpleasant symptoms and prevent complications from secondary bacterial infections.

If you suspect a bacterial infection, but your child is comfortable, I can examine your child during office hours. If there is a fever persisting more than 48 hours, difficulty breathing, pain, decrease in awareness of their surroundings, persist vomiting, or bloody diarrhea, you should call me or go to Children's emergency room.

*Last reviewed July 16, 2007*

---

### **Hand, foot, and mouth disease**

This disease occurs in the summer and fall months. It is not related to any serious cattle disease. Instead, it is a viral disease that spread through some child care facilities and among some families.

It is harmless for most young children. The virus causes small to large ulcers in the mouth. Pustules may appear on the palms of the hand or soles of the feet. The buttocks may also develop a rash. Fever may occur but if it persists beyond two days, I recommend an office exam.

A possible complication is dehydration, because the oral ulcers can be severe and the discomfort will discourage fluid intake. This complication is unusual. Like most illnesses with rashes, your child is contagious for a couple of days before the rash appears until it fades.

---

### **Stomach flu or gastroenteritis**

This viral infection should not be confused with “bacterial” food poisoning caused by improper food handling. “Stomach flu” is a viral illness so there are no antibiotic cures for the vomiting and diarrhea symptoms. Tylenol™ helps the pain from the cramping.

The important concepts to remember are concerning fluid replacement. Understanding which type of fluids and solids you can use will help in the treatment.

The goal of treatment is to avoid dehydration. Fortunately, few children have this complication. (See the section on Vomiting and Diarrhea...)

Start with small amounts of clear fluids. Avoid dairy products because they are not easily digested and can aggravate diarrhea. Even dilute fruit juices can stimulate the diarrhea and should be avoided. If clear fluids are tolerated in larger amounts over an 8 to 12 hour period, consider solid foods. The BRAT diet is an acronym for Bananas, Rice, Applesauce, and Toast. These are easily digested and help thicken the stools. Continue this diet until the stools approach normal for a couple of days.

---

### **Roseola (baby measles)**

Roseola is one of the classic illnesses of early childhood. It is confused with the less common German measles and hard measles or rubeola. The rash of roseola is preceded by several days of sustained high fever, up to 105°. Even though there is a high fever, your child will appear well. A rash then appears after the fever disappears.

It may be slightly elevated, pink or light red. Mild cold symptoms may also develop. A very small number of children who are susceptible may have a convulsion with the fever. This is not epilepsy and will cause no long lasting effects.

This is a contagious illness caused by a virus. The contagious period is just prior to and during the fever. It is treated the same as any febrile illness to provide symptomatic relief. Use aspirin-free fever relievers. Children with prolonged high fevers lasting more than two days should be examined. If fevers persist more than a few days, blood counts or similar laboratory examinations need to be performed. Occasionally some children will need to be hospitalized for observation to rule out serious infectious illnesses.

---

### **Ringworm**

Ring worm is a common skin infection caused by a fungus that invades the superficial layers of the skin. The name refers to the “ringed” appearance of the red rash. The rash begins as a round, small, red spot or pea sized bump. It’s center slowly pales, giving the appearance of a red ring. The ring grows, leaving a red, raised scaly rash which can be grouped or singular anywhere on the body.

Fortunately, it can be treated with readily available over-the-counter medications like Tinactin™, Micatin™, Lotramin™ or Lamasil™. I prefer Lamasil™ but there are many different medications available. Treatment consists of spreading the cream or ointment sparingly over the rash twice a day. There should be dramatic improvement over a weeks time. If the rash does not improve or it worsens, I should see the rash in my office to determine if an infection or if some other condition exists.

---

### **Chronic fatigue in children.**

A diagnosis of chronic fatigue has great appeal. It gives parents and children a socially accepted explanation for long-lasting complaints and some physicians a label for an otherwise baffling set of symptoms.

In part this is due to do with the nature of the Epstein-Barr virus, the virus that causes mononucleosis. Most adults, and many infants and children have been infected with this virus at some point in their lives (90%). Assessing these patients is a difficult task. Most have normal physical examinations and laboratory tests, despite testing positive for the virus in the

past. It is rapidly becoming apparent that most patients with “chronic fatigue syndrome” do not have an active case of the virus. We do know the Epstein-Barr virus can cause many illnesses ranging from mononucleosis to a prolonged and intermittent infection can even cause death, in severe cases.

To diagnose severe, chronic EBV infection, I consider: a severe illness lasting more than six months; evidence of involvement of the bones, eyes, lymph glands, liver or lungs. Special laboratory tests may be helpful in confirming the diagnosis. A chronic fatigue syndrome that meets my specific criteria is uncommon in children and adolescents.

Complaints of prolonged fatigue are common among teenagers. Small children rarely complain of “feeling tired,” and even children with chronic disease rarely complain of fatigue. The concerned parent usually observes and reports that the child appears fatigued. Parents say things like, “He has no energy,” or “All she does is lay around the house.” They describe a child who prefers sedentary activities, looks tired or droopy, has no energy, seems bored, doesn’t want to play with friends, and generally shrinks from social contacts. Many children experience periods of lassitude from time to time. But, children who go through protracted and severe periods of chronic fatigue and withdrawal from usual activities may be suffering from a serious depression.

They will need special medical or psychiatric treatment.

Adolescents complain about being fatigued quite frequently. In fact, fatigue is among adolescents most common problems in pediatric practice and one that arouses much concern in parents, particularly in spring, when adolescents suffer from a combination of fatigue and mild depression. Springtime is the season of the greatest school-related stress, before final exams, grades, college acceptance, prom time, and graduation. These symptoms should definitely be called “spring fever.” All the uncertainties of adolescence including identity and sexual crisis, may create spring fever anytime of the year, with fatigue the major complaint. Many of the adolescence who come to my office with complaints of fatigue and no other problems have an emotionally based problem, usually a product of stress and anxiety.

This is a complex problem that may take time to work through. It should be discussed with both parents and child or adolescent.

---

## **Impetigo**

Children’s skin is more susceptible to infections from fungus and bacteria.

Impetigo is caused by bacteria like streptococcus or staphylococcus commonly found on all children and adults. This skin infection looks like a yellow or honey colored crust. It may start as a small red bump, a pustule or tiny scab. In areas frequently scraped or rubbed, especially around the nose and buttocks. It often follows colds or hayfever when extra rubbing around the nose is natural.

Bacteria are growing in and below the crusts. Treatment involves clearing and cleaning the infected areas. Betadine ointment or solution is the best over-the-counter bactericidal agent. Other choices include bacitracin, cortisporin and other over-the-counter creams and ointments. Oral antibiotics and prescription creams may be necessary for nonresponsive infections or infections covering many areas of the body at once.

These infections are very contagious. Your child may be required to stay home until the infection responds to treatment and clears up.

---

## **Influenza or (FLU)**

Influenza or “true flu” is a viral disease common in winter months. Adults use the term as a general description for many combinations of symptoms. I always ask parents to explain the symptoms. When “flu” appears, epidemic numbers of children and adults are affected. Type A virus is the most common strain, but during some years, Type B strain will occur. A second illness can occur in the same season, giving the false impression of a relapse. When, in fact, the second illness is caused by a different strain of virus.

The virus takes about 2 to 3 days to develop before your children will show any symptoms. Older children can become ill quickly with fever, flushed face, chills, headache, muscle ache

and fatigue. Temperature from 102° to 105° are common. Dry cough, runny nose and eyes appear early in the illness. You will notice sore throat and teary, burning, achy, light sensitive eyes. Up to 1/3 of children will have some diarrhea.

In younger children, the symptoms can be more severe, with a high degree of secondary infections like pneumonia, sinusitis or ear infections. Flu can mimic other illnesses like croup, bronchiolitis, pneumonia or bronchitis. Severe complications like Reye's syndrome (a rare condition leading often to death or brain injury) can develop when aspirins are used instead of Tylenol™. I do not recommend the use of aspirin during influenza season when respiratory illnesses are more common.

“Flu” or influenza can be prevented by taking a series of two vaccines, starting in early fall. I recommend flu vaccine for any child with a chronic illness like severe asthma.

A drug called amantadine hydrochloride or Symmetrel™ can prevent influenza A and is also used to treat the illness. If you suspect your child has influenza, contact my office to schedule an appointment. If your child has influenza, early treatment can reduce symptoms in 12 to 24 hours. I have used Symmetrel™ safely for many years, with excellent results.

---

### **Jaundice with hepatitis**

This disease strikes terror in families because parents fear the worst outcome or have many misconceptions.

Hepatitis is an inflammation of the liver.

Most cases are not recognized because it is generally mild and symptoms are not severe. Its symptoms are nonspecific like fever, headache, general achiness, loss of appetite, or an itchy rash. After a few days, you will notice more nausea and vomiting, stomach ache, and in some cases jaundice (yellowness of the whites of the eyes and skin). Urine will be dark and stools will change to a tan or white color. The area of skin over the liver can be quite tender from the swelling of the liver.

Viruses cause inflammation of the liver including the virus of mononucleosis (Ebstein-Barr virus). Two common forms of hepatitis are infectious or “A” type and Serum or “B” type. Incubation period can vary from 1 month for infectious hepatitis to 6 months for serum hepatitis. Infectious hepatitis is spread from one person to another from intimate contact or from infected water or food. Serum hepatitis is spread by contact with contaminated blood which can occur when infected needles are used or shared or sexual contact.

There is no cure for the viral infection once it develops in the body.

Treatment focuses on meeting the nutritional needs of the infected child. Foods should be lower in fats and contain only mild to moderate amounts of proteins. Carbohydrates are easier to digest than fats or proteins, but all food types can be eaten.

If a member of the family is known to have infectious hepatitis, all family members may receive immune globulin to prevent or to minimize the severity of hepatitis. Once the disease is diagnosed, immune globulin will not stop the infected person's disease. Some children and adults can have damage to the liver or chronic hepatitis. It is important to prevent cases of hepatitis, whenever possible. Fortunately, there will be complete recovery from infectious hepatitis in more than 90% of children.

---

### **Lyme disease**

Lyme Disease is a bacterial infection transmitted by the bite of the small mouse or deer tick. Symptoms are fever, body ache, and rash. Later, symptoms like irregular heart beats, convulsions or arthritis may develop. This disease can cause serious problems, but it is rarely fatal. Any stage of the disease can be successfully treated with antibiotics.

The first stage of the disease begins from 3 to 30 days after the tick bite. The characteristic rash can be flat or raised and red. There is a ringed border with a pale center. The size may be ¾ inch to 26 inches across. Later other rashes may appear accompanied by fatigue, fever and headache.

Stage two develops after a brief period of well being. Then the headache, stiff neck, nausea, vomiting, fatigue, memory loss and loss of concentration may occur. Facial nerve

paralysis, irregular heart beat can also develop in this stage. In stage three, the last stage, weeks, months or years may pass before arthritis appears.

There are no accurate tests to detect Lyme disease in stage one. The combination of flu symptoms, rash and tick bite are necessary for diagnosis. The later stages can be more accurately tested. Treatment with common antibiotics is generally successful.

To prevent Lyme Disease wear light colored clothing so the tick may be easily seen. Wear long pants tucked into your socks. Remove ticks promptly. Use tick repellents containing 30% DEET or 0.5% Pyrethrins. Tick collars for pets are recommended. This tick is not native to our area so unless you have traveled to an area where it is common, you should not be concerned about Lyme Disease.

---

## Tuberculosis

Tuberculosis was once a common disease in the early and middle twentieth century. It has decreased in frequency, but has recently made a comeback, especially in the middle adult years. In Fresno county the disease has made a rebound too, because of the influx of immigrants from Mexico and Central and South America.

Tuberculosis is spread by inhaling infected droplets. The infected person coughs and sneezes, spreading the infection. Adults who have the disease need to cough large amounts of the infected droplets to spread the disease to a child.

Children 3 to 15 years are likely to develop primary tuberculosis, if infected. This form of Tuberculosis is usually asymptomatic. There is no fever, cough, fatigue, or other symptoms. It is picked-up or diagnosed by the simple skin test that we do in the office. X-rays are often negative. Tests to cultures or examine the bacteria are difficult to obtain, because sputum is necessary to culture. Most small kids swallow their sputum so testing them is difficult.

Because tuberculosis requires large amounts of infected particles to be coughed up and spread, it is very unusual to contract TB from a casual exposure. It is also unusual for a child to spread it to another child. The classic exposure is from an older adult with long established disease to another person after prolonged exposure.

Treatment is by drug therapy. Up to a year of drug therapy is necessary to eliminate the infection.

---

## Skin infections

Shortly after birth normal infants are exposed to a whole range of different bacteria, viruses, and fungi. As we grow, infants and children establish colonies of many different organisms that do not harm the body.

Even though we might take exceptional good care of our children's skin, permanent colonies of microorganisms develop. Only when the normal checks and balances of the body are effected, will you notice the presence of an infection.

The skin might not be the only location for the spread of viruses, bacteria, or fungi. Some infections invade deeply advancing into the blood system, spreading throughout the body or adjacent organs.

The skin is naturally dry. The first locations for infectious overgrowth will be in areas where moisture is increased. The groin, underarms, around the neck, and feet are frequent sites for infections to grow or spread.

There are many common types of bacterial infections found. Here is a brief list of the those I see: impetigo, folliculitis, furuncles, carbuncles (boils), paronychia, and cellulitis.

Infections are first noted on the outermost areas of the skin. Impetigo is one of the most common skin infections in children. It can start as a simple small red bump or flat area. It progresses to form a small white head or larger collection of pus. Drainage can occur on its own with crusting. This crusting is generally honey-colored. Bacteria grow in the collection of crusts and continue to reinfect the skin.

As the parent you can help to control the infection by removing the crusts with medicated ointments, cremes, or lotions. This will reduce the reinfection of the skin. Over-the-counter neosporin, bacitracin, or Betadine are just a few examples of possible medications.

Other forms of impetigo appear as large pus-filled blisters. This is more common in the diaper area and between the thighs. This is called bullous impetigo and needs antibiotic treatment with oral medications.

Deeper infections can produce pain and fever. In most cases these infection called cellulitis start as a simple pimple but grow involving deeper zones of the skin, muscle, and bone. The skin might be red, tender, and swollen.

These are definitely more serious and require my care. Close doctor follow-up is necessary to avoid progression of the infection into the body organs or the blood system.

Some infections start at the hair follicle and cause redness, irritation, pain, and sometimes a discharge of watery, yellow, or bloody fluids. Soaking these with water might be your first option. It will help if you keep the area clean with soap and water and then dry well.

On occasion small areas of infection group and form an abscess which will require minor surgical drainage. I recall a recent patient account where a well-meaning parent tried to clean and drain an infection around a nail by lancing it with a needle. After repeated attempts at draining the area, the infection grew. It invaded the bone in the finger. The destruction of the bone infection eroded the end of the finger bone, leaving his finger tip shortened by about an inch. Don't try to drain an abscess at home with a needle. Very serious complications can result.

A form of skin infection called Methacillin Resistent Staph Aureus (MRSA) is now appearing that is resistant to common antibiotics. There are two forms. One is a community acquired form which is less serious and can be treated in the office. It can reoccur. The other form is acquired in the hospital with patients that often have chronic illnesses and their form requires care from an infectious disease specialist.

*Last reviewed July 16, 2007*

---

## Pinworms

Pinworms are the most common type of intestinal infection in children in America. The adult worm measures about ¼ of an inch in length.

You can barely see it without a magnifying glass. Pinworms cause no symptoms in the majority of children they infest. You cannot get an infection from pets only from another infected child or adult.

Symptoms caused by pinworms are usually confined to the areas surrounding the rectum, although in girls the worms can cause symptoms in the vagina. There may be itching and pain or restlessness at night. Many children grind their teeth.

You may be able to see the worms migrating at night near the rectum. Take a flashlight at night while your child is sleeping.

A chewable prescription medication kills the worms. If more than one person in the family is infected, I will treat the whole family at the same time.

---

## Valley Fever

Coccidiomycosis is the correct name for a fungal infection found in areas such as the San Joaquin Valley. It is sometimes called San Joaquin Valley Fever. The spores are inhaled and later develop in the tissues of the lung.

The infection is self-limited and harmless to most who are infected. Two thirds of those infected do not develop any symptoms of the disease. Others will show effects to the tissues of the lungs. A rare few develop an over-whelming infection and sometimes die. The disease tends to be milder in children. Some children will show infection of their bones or the tissue surrounding the brain. The period of incubation is about 10 to 16 days. The illness might develop slowly or quickly with signs of influenza-like illness with fever, chills and body ache. The can be a persistent cough and painful sore throat. There might be headache, backache or chest pain.

There may be a fine red round rash or hives might appear within a day or so. The rash might last a few days only or appear as tender bumps. At the same time you might notice an arthritis or conjunctivitis.

Signs of pneumonia can appear. It is usually minor but can be quite severe.

The diagnosis of Valley Fever can be made by skin test but a negative test does not rule out Valley fever so I will order a complete cocci blood test. This will be more accurate and gives dependable results.

There is no treatment recommend for primary, uncomplicated Valley Fever. Rest is helpful, but not is not required. You can only contract the disease by breathing the infectious spores and will not be contagious to others will the disease is active. One infection should establish immunity for future infections. There is no effective vaccine for this disease.

## Incubation Chart

### Infectious Disease Incubation Chart

Disease	Incubation Period in Days	Contagious Period in Days
<b>Skin infections</b>		
Chicken Pox	14-16 days	2 days before rash until all sores have crusts
Fifth Disease (Erythema Infectiosum)	10-14 days	7 days before rash until rash begins
Hand Foot and Mouth Disease	3-6 days	Onset of mouth ulcers until fever gone
Impetigo	2-5 days	Onset of sores until 24 hours on antibiotic
Lice	7 days	Onset of itch until one treatment
Measles	10-12 days	4 days before rash until rash gone (7 days)
Roseola	10-15 days	Onset of fever until rash gone (2 days)
Rubella (German Measles)	14-21 days	7 days before rash until rash gone (4 days)
Scabies	30 days	Onset of rash until 1 treatment
Scarlet fever	3-6 days	Onset of fever or rash until 24 hours on antibiotics
Shingles- contagious for Chicken pox	14-16 days	Onset of rash until all sores are crusted (7 days)
Warts	30-180 days	minimally contagious
<b>Respiratory infections</b>		
Bronchiolitis	4-6 days	Onset of cough until 7 days
Colds	2-5 days	Onset of runny nose until fever gone
Cold sores (herpes)	2-12 days	<6 years-stay home until sores are dry (5 days)
Coughs (viral)	2-5 days	Onset of cough until fever gone
Croup (viral)	2-6 days	Onset of cough until fever gone
Diphtheria	2-5 days	Onset of sore throat until 4 days on antibiotics
Influenza	1-2 days	Onset of cough until fever gone
Strep Sore throat	2-5 days	Onset of spre throat until 24 hours on antibiotics
Viral sore throat	2-5 days	Onset of sore throat until fever gone
Tuberculosis	14-70 days	Until 2 weeks on drugs(most childhood TB is not contagious)
Whooping cough	7-10 days	Onset of runny nose until 5 days on antibiotics
<b>Intestinal Infections</b>		

Diarrheal, bacterial	1-5 days	<6 yrs. Stay home, > 6 yrs return if BM control and no fever
Diarrhea, giardia	7-21 days	same
Diarrhea, Travelor's	1-6 days	same
Diarrhea, viral (Rotavirus)	1-3 days	same
Hepatitis A	14-50 days	2 weeks before jaundice begins until jaundice resolves
Hepatitis B	50-180 days	
Pinworms	21-28 days	minimally infectious
Vomiting, viral	2-5 days	Until vomiting stops
<b><u>Other Infections</u></b>		
Infectious mononucleosis	30-50 days	Onset of fever until fever gone (7 days)
Meningitis, bacterial	2-10 days	7 days before symptoms until 24 hours of IV antibiotics
Mumps	16-18 days	5 days before swelling until swelling gone (7 days)
Conjunctivitis, viral	1-5 days	Until redness resolves
Conjunctivitis, bacterial	2-7 days	Onset of discharge from eye until 1 day of antibiotics

## Safety and Prevention

### Safety Check List

A car seat and safety belts are the best investment you will ever make for your child's long life and safety.

Always keep one hand on the baby while bathing or while he or she lies on the bed.

Check water temperature before bathing.

Keep pins closed and small objects out of reach.

Keep toys free of splinters and sharp edges; remove loose parts which may be swallowed.

Keep your baby away from hot stoves, radiators, pipes, open fires, barbecues or cigarettes.

Do not lay the baby on soft, heavy pillows which can lead to suffocation.

Keep electric sockets closed and cords out of reach.

Furniture and lamps should be secure or out of reach so they cannot be pulled over onto the baby.

Keep all medications, poisons, solvents or harsh chemicals out of reach and locked up. (see Poisons...)

You should purchase an ounce of syrup of ipecac at the drug store to have on hand should poison control or I should advise this to induce vomiting of an accidentally ingested poison. This should only be given on my advice or the advice of poison control.

Swimming instructions start at 3 to 5 years of age. Please fence your pool and learn CPR especially if you own a pool.

All children, adolescents and their parents should wear safety helmets or head gear when riding bikes.

Ask me if you have any questions on safety issues.

---

### Head injuries

Head injuries occur throughout the year in all age groups. Many parents call me to ask about what to watch for after the injury.

When a head injury occurs, I will need to know :

1] How the injury happened

2] Whether there was a loss of consciousness?

3] Whether there seem to be any after effects like: loss of alertness, damage to the skin, etc.

Answers to these questions help me decide whether substantial brain injury occurred. Falls from great heights, or from a car or deep puncture wounds are reason for an office exam. If there was a loss of consciousness for 5 minutes or more, or a shorter loss of consciousness followed by persisting headache or vomiting, an exam may be required. When the head injury causes persisting symptoms like : repeated vomiting, severe headache, unequal pupils, unsteady walk, convulsions, personality changes or loss of awareness as to surroundings, an exam is necessary.

You may notice a large "goose egg" on the head within minutes of the injury. **THIS IS COMMON AND NOT A SIGN OF A SERIOUS INJURY!** Unless this swelling is also accompanied by the warning signs in the preceding paragraph, just relax and let your child rest. Give Tylenol™ or aspirin for a potential headache.

---

### Things kids choke on

For small children under 1 year, choking is the leading cause of accidental death. Parents are more aware of the dangers of choking for infants and children under four years old. Choking is a risk for any age when play or exercise is combined with eating. Certain foods such as nuts, popcorn, grapes, carrots, hard candies, hot dogs, or gum are potentially greater risks for choking.

Children under three to four years of age are not yet ready to grind their food with their molars. They use a shearing or biting action which can shoot the food backward into the

airway or “windpipe.” This can interfere with air entering the lungs and can be fatal. Hot dogs and grapes should be eaten cautiously after peeling and chopping into small pieces.

Toys can be dangerous, too. Inspect toy boxes carefully. The recommended ages written on the box are a guide to the safety of that item. A toy may be safe for an older sister in the same home but totally unsafe for a younger brother. Manufacturers base recommended ages on the sizes of the toy pieces. Large pieces that are too big to block the throat will be safe for younger children. Toys sold at swap meets may not be marked with the age that can safely play with the toys. These toys are safety hazards and should purchase with caution. Items that frequently cause problems are: watch batteries, buttons, coins, jacks, safety pins, and balloons.

Warning signs of choking are: unable to talk or make a noise, turning blue, gagging, sudden breathing difficulty or high pitched voice. If a second person is present, call 9-1-1. Do not try to dislodge the object if your child is coughing. Coughing is the best defense against blockage of the airway.

---

## First aid

### **Burns and Scalds** Minor Burns without blisters

Place burned extremity into cold water or cover burned part with a towel soaked in cold water until the pain stops at least 15 minutes. Do not use ice.

### **Burns with blisters**

See above. Do not break the blisters. Call me for advice on how to cover the burn. Any burn on the face, hands, feet, or genitals and any large burn should be seen by a doctor.

### **Large or deep burns**

Call 911 or an emergency ambulance. Remove clothing. Do not apply any medications. Keep your child warm with a clean sheet and then a blanket until help arrives.

### **Chemical burns, Electrical burns**

Disconnect electrical power. Do not touch your child with bare hands. Pull him or her away from the power source with dry wood or a thick, dry towel. All electrical burns need to be seen by a doctor.

### **Seizures or Convulsions**

Protect your child from injury. Perform rescue breathing if your child is blue or is not breathing. If breathing, lay the child on his or her side. Put nothing in the mouth. Call 911 or an emergency ambulance.

### **Eye Injuries**

If anything is splashed into the eye, flush gently with warm water for at least fifteen minutes. Call the Poison Control Center or my office for further advice. Any injured or painful eye should be seen by me or the emergency room doctor. Do not touch or rub an injured eye. Do not apply any medication. Do not remove objects stuck into the eye. Gently bandage the painful eye shut until you can get medical help.

### **Fainting**

Lay your child on his or her back with head to the side and legs raised. Do not give anything by mouth. Call my office. If your child does not wake up right away, call 911 or an ambulance.

### **Fractures or sprains**

Do not move a child who may have a neck or back injury, because this may cause serious harm. If an injured part is painful, swollen, deformed, or if motion causes pain, suspect a fracture and splint it. Apply a cold compress and call me or go to Children’s Hospital Emergency room.

### **Head Injuries**

No not move any child who might have a serious head, neck, or back injury, because this might cause harm. Call 911 or an emergency ambulance for any of the following:

- Any loss of consciousness or drowsiness
- Persistent headaches or vomiting
- Clumsiness or inability to move any body part
- Oozing blood or watery discharge from ears or nose
- Convulsions or seizures

- Abnormal speech or behavior

For questions about less serious injuries, please call me.

#### **Nosebleeds**

With child sitting and head bending slightly forward, squeeze nostrils together with thumb and index finger for about 5 to 10 minutes. This can be repeated twice. If bleeding persists you should call my office.

#### **Poisons**

If your child is unconscious, becoming drowsy, having convulsions, or having trouble breathing, call 911 or an ambulance.

#### **Swallowed poisons**

Any non-food substance is a potential poison. Call the Poison Control immediately. Do not induce vomiting except after professional advice. The Poison Center will give you further instructions.

**Fumes, Gases, or Smoke** Get the victim into fresh air. Call 911 or the fire department. If the child is not breathing, start CPR and continue until help arrives.

#### **Skin exposure**

If acid, lye, pesticides, chemicals, or any potentially poisonous substances come into contact with a child's skin, gently brush off the dry material. Remove contaminated clothing. Wear rubber gloves if at all possible. Wash skin with soap and large quantities of water. Call Poison control for advice.

#### **Skin wounds**

For all these conditions, make sure your child is properly immunized for tetanus. Any booster should be effective for about ten years after five year school shots or older 11-15 year shots.

#### **Bruises**

Apply cold compresses for one-half hour. For extensive bruises, crushing injuries, or bicycle spoke injuries, call my office. For continued pain or swelling call my office.

#### **Cuts**

Apply pressure with a clean cloth stop the bleeding. If the cut is large and deep, call for help and maintain pressure until help arrives. For minor cuts, wash with soap and water and cover with a dressing. If a cut might need stitches, seek medical care as soon as possible.

#### **Scrapes**

Wash scrape with soap and water. Cover with a non-stick dressing.

#### **Splinters**

Wash with soap and water. Do not soak splinter. Remove small splinters with tweezers. If not easily removed, call my office.

#### **Puncture Wounds**

Do not remove large objects such as knives or sticks. Call my office. For minor puncture wounds, wash with soap and water and call my office. You should call the office to determine if you will need a tetanus booster. This is not necessary if the immunizations are up to date.

#### **Stings and Bites**

Remove the stinger with the scraping motion of a fingernail. Do not pull the stinger out. Put a cold compress on the bite to relieve the pain. If hives, paleness, weakness, nausea, vomiting, tightness in the chest, breathing difficulty, or collapse occur, call 911 or an emergency ambulance. For Black Widow spider bites call Poison Control.

#### **Animal or Human Bites**

Wash wounds with soap and water and call the office.

#### **Ticks**

Place tweezers close to the head of the tick and the pull the tick away from the point of attachment. Call my office if the head remains attached, or if your child develops symptoms such as fever, rash, or headache.

#### **Snake Bites**

Call the Poison Control Center for snake bites. Do not apply ice. Take your child to Children's Hospital Emergency room as soon as possible.

Splint the injured arm or leg. Keep the injured arm or leg elevated if possible.

### **Teeth**

#### **Baby or Primary Teeth**

If your child's teeth are knocked out or broken, apply clean gauze to control the bleeding and call your dentist.

#### **Permanent Teeth**

If knocked out, find the tooth and rinse it gently without touching the root. Insert and gently hold the tooth in its socket or transport the tooth in cow's milk. Go directly to your dentist or Children's Hospital. Time is important.

If broken, save the pieces. Gently clean the injured area with warm water. Place cold compresses to reduce the swelling. Go to your dentist immediately.

Consider placing these numbers by the phone in clear view and alert any child care person where these numbers are:

- My Number (Dr. Simonian 325-6850 or after hours 221-3893)
- Police Department...
- Poison Control Center...
- Emergency Department...
- Ambulance or Paramedics...
- Fire Department...
- Emergency Family or Friend phone number...

---

## **Bike injuries**

Warm weather and outdoors activities increase in these warm days and nights.

Kids are riding their bikes and looking at the water for their first dip. Both of these activities are wonderful exercise and fun. As a health professional and a safety activist, I can see another side of the story. Injuries spoil many playtime sports and games. Fortunately, most serious injuries can be prevented. If an injury occurs, the severity can be decreased by proper anticipation.

Anyone can get hurt. A helmet protects against more than broken bones. The facts are:

Head injuries are more than scrapes, bruises, fractures or concussions. Head injuries can effect the brain and ability to reason, hear, see, understand and relate to other people. The damage can be temporary or permanent. The injury can lead to death. The injured person can suffer memory loss, problems with reading, inability to concentrate, mood swings, or impulsive, uncontrollable behavior.

#### **How easy is it to injure the head without a helmet?**

A fall from two feet above the ground can cause a serious head injury. Falls from a tricycle, bicycle, unicycle can easily cause an injury to the brain. Over 500,000 adults and children are treated for bicycle-related injuries in hospital emergency rooms each year. One third of those seen are treated for head injuries. These head injuries could be reduced by 85% if approved bicycle helmets were used.

#### **It won't happen to my child or me!**

Most bike mishaps happen within one mile of home. 75% of bike injuries involve injury to the head. Most injuries on bicycles do not involve a crash with a car but are the result of riding out of control. Falls are the result of riding too fast, showing off or hitting road hazards. Helmets are effective safeguards to protect the head.

Which helmet should I buy? Look for an ANSI or SNELL standard emblem on the helmet. Don't forget to check. You need in insure a correct fit.

How to get your child to wear the helmet?

- let them pick it out
- always insist they wear it
- when you ride together wear your helmet
- praise your child when they wear it
- begin using a helmet from their first bicycle
- encourage other kids to wear their helmet

*Why use a bicycle helmet?*

Bicycle injuries are a more common cause of death in children than accidental poisoning or falls. More than 75% of bike-related deaths involve head injuries. Over 1300 children and adults die each year; the majority of the serious injuries involve injury to the head. Bicycle injuries are the most common cause of head and neck injuries in children, and head injuries account for the majority of deaths in bicycle accidents.

*Adults are very much at risk for head injuries too.*

Adults need to set the proper example for children and adolescents. The U.S. Cycling Federation and the Fresno Cycling Club require helmets in all competitive racing events. Many cycling clubs require their members to use proper helmets in all their events and training. These same organizations along with many professional health organizations like Children's Hospital and the Fresno-Madera Medical Society are trying to educate adults and children about the importance of helmet use.

If a helmet is used, a child, adolescent, or adult can reduce their chances of death or disability by 85%; at least, the severity of the injury will be greatly lessened.

---

## Swimming pool injuries

*We always watch our kids and nothing ever happened* Most injuries happen when at least one adult is at home..

The adult thought the child was safely away from the pool. They believe another adult is watching the child. The last place searched is the swimming pool. Only minutes separate a normal child from being brain-damaged or dead. A survey on near-drowning conducted in Fresno showed one out of four families said their child had a near-miss where the child might have suffered an injury if the adult had not arrived and rescued the child.

*I would hear my child and rescue him or her.*

The average age for a pool near-drowning or drowning injury is 2 years. The child enters the water reaching for an object such as a toy and silently sinks. There is no warning, noise or disturbance. This can happen even while you are near them with your back turned.

*I will teach my infant or toddler to swim.*

Most water safety experts from the *American Academy of Pediatrics* and the *American Red Cross* recommend swimming instruction for children around 3 to 5 years of age. Earlier instruction is poorly retained. Toddler's don't reason well enough to respond in an emergency. These toddlers don't understand the dangers of deep water any more than stairways or open windows.

*I don't have any children so extra safety measures around my pool are not necessary* (for example, pool fencing).

There are very few households where children never visit. These adults are not prepared for the constant challenging young children place on their surroundings — climbing, pushing and testing. It is not possible to supervise children every second, so extra safety measures are essential. For example, safety fencing, separating the home and the pool, alarm devices alerting the adult about children leaving the home or self-closing, latching sliding doors or safety pool covers. Recognized standards for safety must be in place for everyone for the benefit of the majority.

*Very few children drowning in swimming pools each year. Why the concern?*

In the Fresno area, around 10 children drown every year and at least 3 are swimming pools in the family's backyard. Thirty children are hospitalized for near-drowning every year and more than 80% are in the family's backyard inground swimming pool. Three or four of those children hospitalized will have severe brain injury. Children with near-drowning brain injuries can cost a family over \$100,000 a year for their care.

*Educating the parent and the child is the real answer.*

Education of the adult and the child is extremely important so they understand the risks of injury, and methods to reduce the chance for injury. Eighty percent of pool injuries and most of water injuries around the home involve very young children under 4 years of age. No one should expect a direct education program to be effective for these children. Preventing their

easy access to the water by direct supervision and physical barriers would be the most effective methods.

---

### **Roller-Blades, roller skates, or skateboard**

Roller skates, the in-line style known as roller blades are common. What most parents aren't aware of is the great speeds attainable. These more sophisticated skates are visible everywhere.

The vohue thing to do is tricks and parks are being build just for their use. Emergency rooms are reporting many more accidents than a few years ago after the popularity of roller skates started and skateboard acrobatics now so popular. You or your children are not wimps if you consider a few safety precautions if you plan on using this new, speedier mode of travel.

1. Wear a helmet, intended for use with skate board or roller skates, along with knee pads, elbow pads, and gloves.
2. Skate on smooth, paved surfaces without any traffic. Avoid skating on streets, driveways, or surfaces with water, sand, gravel or dirt.
3. Learn to stop using the brake pads on the heel.
4. Do not skate at night because it is difficult to be seen or see hazards in your path.

---

### **Sprain**

Your older child is active and involved in sports. You might be an anxious by-stander or the pseudo-coach. Somebody twists their ankle, wrist or knee. They are right back up and play resumes, but you worry how to treat that minor injury.

I use the pneumatic device R.I.C.E. for most minor injuries seen in the office. "R" is for rest. The period of rest might be hours or weeks depending on the severity of the injury. If your adolescent requires more than a couple of days of rest, you need to call me at the office. "I" is for ice. Cold is necessary to reduce the swelling. You can use regular ice wrapped in a towel or a chemical coolant available at drug stores. One trick I like for home use is a bag of frozen peas. They mold to the injured area and are available in most homes. "C" is for compress. A compression dressing like an ace wrap will control the swelling and give mild stability for the injured joint. "E" is for elevate. Elevating the foot or knee will reduce the swelling common even with minor injuries and uses gravity to reduce the fluid buildup in the tissue from the injury.

Most injuries can be watched at home and managed without my medical care. If your adolescent can't bare weight on the injured limb, has intense pain without relief from Tylenol™, has swelling that feels like Jell-O or is mushy, I should examine them. These cautions don't apply to a preadolescent who doesn't get sprains easily. Children will fracture a foot or arm before they sprain it. It has to do with ligaments and tendons being stronger than the developing, soft bones. If you think your child has a sprain, it could be a fracture. Call the office if you believe there is a substantial injury.

---

### **Smashed fingers and toes**

Children will find unlimited ways to smash their fingers or toes. Just use your imagination and the ways are endless — fingers caught in doors, drawers or windows; fingers smashed with hammers; toes crushed by heavy objects. If the injury involves only the end segment of the finger or toe and does not produce a serious cut, it probably won't need my attention. Fractures of the end segment of the finger and toes usually don't require treatment, but when they do, I normally splint the finger or toe. You can do this yourself by taping an adjacent healthy finger or toe to the injured one to stabilize it.

If the injury involves other parts of the finger but your child can move it easily, then treat with an ice pack for swelling and Tylenol™ for pain.

Fingernails are frequently dislodged by these injuries. The entire nail usually doesn't need to be removed but any portion extending outward can catch on clothing or the surroundings. Clip this portion off. Nail regrowth can take 4 to 6 weeks.

---

**Cuts**

Cuts are common occurrences in children and adolescents.

Parents worry about controlling the bleeding and preventing an infection.

Scratches are injuries to the surface of the skin only. There is usually little bleeding or the bleeding is quickly controlled by pressure with a clean dressing. Clean the wound with soap and water or use Betadine or a similar antiseptic solution. Using over-the-counter antibacterial ointments is optional.

Lacerations or deep cuts are more difficult to treat without my assistance. Bleeding that cannot be controlled with simple pressure may need to be stitched. Irregular wounds or longer or deeper wounds showing the fatty underlying layer need suturing. If the wound is in an exposed area of the skin, suturing may improve the future cosmetic appearance.

## Stomach and Intestines

### Vomiting > 24 hours.

Vomiting is a non specific sign of many illnesses but it usually means there is some type of gastrointestinal infection. Call right away if your child is :

1. Very weak or fatigued and often associated with a temperature above 101°.
2. has bile stained (green colored) vomitus on two occasions.
3. has not urinated for 8 hours.
4. appears pale, and unaware of the surroundings.

Treatment to be started if your child vomits more than once in twelve hours:

Under 6 months use : Pedialyte ½ to 1 ounce every 30 minutes. If that is tolerated well after a few attempts, then increase the volume by one ounce every 30-60 minutes. Once they reach the amount of fluid that is about normal for them continue with Pedialyte for 12 to 24 hours. You should then return to breast milk or half strength formula for one day followed by full strength formula.

Older infants, children and adolescents can be given water, Gatorade, 7-up, tea, or Jello. Avoid milk for a few days if there is any sign of diarrhea. Milk sugars are not digested well and can produce more diarrhea. Advance their diet slowly over the next couple of days until you are back to normal. If they continue to vomit after 2 or 3 consecutive trial doses of clear fluids or they start #1, #2, #3 or #4 above - call me or go to Children's Hospital emergency room.

---

### Diarrhea

Diarrhea means bowel movements, not of the regular consistency - usually watery, and more than once in 24 hours. Diarrhea is a non-specific sign of many illnesses but it usually means there is some type of intestinal infection.

Call right away if your child is:

1. very weak and has a fever over 101° degrees
- or 2. has grossly bloody stools
- or 3. has not urinated for 8 to 12 hours
- or 4. appears very pale and unaware of her surroundings

#### *Treatment*

Under 1 year of age use Pedialyte or a similar hydration fluid for about 24 hours. If there is improvement with less frequent bowel movements or thicker stools, then use ½ strength Isomil™ or other soy formula; then in the following days you can try using full strength soy formula for about one week.

For older children or adolescents, begin with clear fluids with Gatorade, 7-up, tea, and even water. After about 24 hours and improvement in the diarrhea try the "BRAT" diet: Bananas, rice (cereal), apple sauce and toast. For older children baked or fried potatoes, crackers, simple broth or soup may be tried. Avoid regular non soy formulas until the stool returns to normal. Avoid milk or dairy products because milk sugars in dairy products can worsen the diarrhea. Also avoid fruit juices that can worsen diarrhea. If there is no response to treatment in 1 to 2 days or the symptoms worsen - please call me or go to Children's Hospital emergency room (353-3000).

---

### Constipation

Most infants have several bowel movements a day. Some will skip one or several days in their normal pattern. Most breast fed infants have loose stools, but some are prone to infrequent bowel movements. Many babies grunt and others turn bright red for a couple of minutes while they pass a stool or pass gas. The first appearance of this behavior may be startling for the parent. The baby is not in distress or is constipated.

The infant with a real bowel problem will have definite symptoms besides the infrequent bowel movement: Pain on the passage of stools, inability to complete a normal movement although the urge is strong and blood in the stools.

---

**Constipation treatment**

If you use formula, add more water and sugar (not honey) to the formula. Try one teaspoon to one tablespoon of Karo™ syrup per four ounces of liquid.

If there appears to be a “crisis” (your baby is crying and trying to push but nothing is happening), you can buy over-the-counter medications at any pharmacy and use Babylax™ or glycerin suppositories until a BM can be obtained. If treatment is needed two or more times a week, please call my office.

---

**Constipation in older children**

Constipation can occur at any age. It can be very uncomfortable. Children can develop problems if constipation occurs on a regular basis. The problem may start innocently by controlling BM's because they want to play longer, had a painful or bloody stool once or are embarrassed to use the school facilities. Holding their bowel movements in a chronic manner can eventually cause stretching of the intestinal lining. A vicious cycle of pain and withholding can develop. If this persists over months or years, leakage can cause embarrassing soiling of underwear and an accompanying odor.

I am impressed with the help a simple change in diet can achieve. Increase the amount of bulk in the diet. Leafy vegetables, fresh and cooked fruit and fruit juices or extra liquids work well. Keep dairy products down or stop all together.

When dietary changes don't work, a more aggressive treatment may be needed but I will need to examine your child before using medications.

---

**Rectal pain, itching or bleeding**

Rectal bleeding is not a common problem in children. It is usually seen in a diaper change when a few streaks of blood are noticed over the surface of a stool. In infants, the cause is a small tear in the rectal opening. This is not serious and heals without special treatment. Hard stools cause the problem, but I have also seen it after straining on soft stools. Treating the constipation clears up the bleeding.

If the problem persists after several bowel movements or over several days, please call my office.

If rectal bleeding accompanies abdominal pain, there may be a blockage of the intestine or a bacterial intestinal infection. Either of these problems requires prompt attention.

A child may awaken in the evening with intense rectal pain or itching. This almost always means an infestation of pinworms which are seldom seen but are quite common. These very small worms live in the intestine near the rectum. The female emerges at night to secrete a sticky and irritating substance around the anus where she lays her eggs. The worms can move into the vagina causing pain and itching. Scratching can lead to secondary bacterial infections.

Pin worms are easily treated with a chewable drug that effectively kills both the worms and eggs. (*see also the section on Pin Worms*)

*Last reviewed July 16, 2007*

## Respiratory Problems and Lungs

### Asthma

Parents are mystified by the term asthma. It is important to understand asthma, because it is the most common chronic respiratory disease in children and adolescents. Asthma affects the bronchial passages of the lungs. When an asthmatic child is affected by this condition, the bronchial tubes become narrow, making it difficult to breathe. This happens because small muscles surrounding the bronchial passages constrict, the lining of the bronchial tubes becomes swollen and extra mucus blocks air flow.

Many different symptoms can appear, if asthma is active in your child. Some children have the feeling of tightness or pain in the chest as they breathe. Some children with a mild but persistent form of asthma, can appear fatigued. They show signs of strain and working to breathe. Other children may have only a nighttime cough lasting for weeks or months. Some others will cough with play or exercise.

As I mentioned, cough is an important sign in asthma. The term “attack” is often used to describe fierce bouts of coughing, making it difficult to breathe. In some cases, coughing is almost absent. The strained effort to force out air trapped in the lungs, produces an unique sound called wheezing. Many different factors can start the symptoms of asthma.

In children, infections are the most common trigger. Asthma and allergies are often used interchangeably with each other, but they are not the same. Allergies are reactions to foreign substances like house dust, animal dander, pollens, molds, medications, and foods. These substances cause the body to produce histamines, which are chemicals that produce swelling, redness, itching and irritation. Not all allergic children have asthma, and many asthmatics are not allergic.

Changes in temperature or weather can start the symptoms of asthma. Exercise can also bring on the symptoms of asthma. Certain types of exercise seem to be tolerated easily like swimming, whereas long-distance running and basketball seem to be tolerated less. Irritants very commonly cause a child’s asthma. Cigarette smoke, chemical sprays, air pollution, gasoline, and perfumes are examples of irritants that can cause a child’s wheezing or cough.

Emotions can play a role in causing an asthma attack, but this can easily be over-played as a cause of asthma. Some asthmatics will develop complications with their asthma, although most problems can be avoided, if asthma is managed appropriately. Many asthmatics have secondary infections like ear and sinus infections. Pneumonia can develop if the symptoms go untreated.

The diagnosis of asthma is customarily made from the symptoms present, and the medical history of the child and family. Sometimes chest and sinus X-rays are valuable to determine if an infection exists. Sinusitis may hinder the rapid resolution of symptoms. Pneumonia can produce the same symptoms as asthma.

When a strong allergy history is present, allergy testing can help determine the cause of asthma. This testing is usually restricted to children over 5 years, because the results are not specific or dependable for children under 5. There are many effective treatments for asthma. If any symptoms of asthma are present in your child, an office visit is recommended.

---

### Smoking and your child

Parents should be aware of all the new information available about the effects of the secondhand and sidestream smoke

{ XE “cigarette smoke” } on your child’s health. Secondhand smoke is all the smoke from the parent when they exhale and sidestream smoke is the smoke rising from the end of the cigarette while it is burning.

It is said that a child who spends one hour a day in a very smoky room with multiple smokers, inhales as much harmful chemicals as if he or she smoked 10 or more cigarettes.

Some of these same harmful chemicals are present in the breast milk of a smoking mother. Smoking parents and *Sudden Infant Death Syndrome* appear to be linked. There is an increased rate of *SIDS* in homes where there is secondhand smoke.

I always caution parents who smoke who have asthmatic children. Their frequency of complications, the frequency of doctor visits, and number of hospitalizations are all increased when an asthmatic child lives with one or two smoking parents.

*There is a long list of conditions that are worsened when your child is exposed to secondhand smoke:*

- pneumonia
- coughs or bronchitis
- croup or laryngitis
- wheezing or bronchiolitis
- influenza (respiratory flu)
- ear infections
- middle ear fluid
- colds and other upper respiratory infections
- sinus infections
- sore throats eye irritation
- school absenteeism

---

## **Secondhand smoke?**

The most important thing is to give up smoking. An especially critical time is during pregnancy. Children's growth is known to be effected by cigarette smoke. Smaller babies are often the result of a smoking mother. Children who grow up in home where one or both parents smoke are 2 to 3 times as likely to be smokers when they make a choice to smoke themselves.

It is easy for me to say stop smoking but it is very difficult to do. At least try to change your smoking habits. Either smoke only when your away from the home. If you must smoke at home please smoke on the patio or garage. When you must smoke in doors use only one room. Try to keep the room well ventilated to the outdoors by opening a window. Even with these measures smoke often permeates through the rest of the house. This should also apply to visitors.

Avoid smoking when you hold your child. Do not smoke in their room. Never smoke in the car when your child is a passenger.

It is also important to check out the care giver for your child. They should not be smokers.

Although we might try to prevent our children from cigarette smoke it is not realistic to expect that they will never be in contact with other smokers. If we do our best to decrease the amount of time they are around secondhand smoke you can expect minimal effects from smoke and decrease the chances for illnesses and disease.

---

## **Bronchiolitis**

Respiratory Syncytial virus (RSV) causes many types of upper respiratory illnesses in the winter months, especially bronchiolitis. It is notorious for causing remarkable coughing that can last for weeks. Many children with bronchiolitis are diagnosed as having pneumonia. Children, particularly infants, may wheeze like an asthmatic and those under 6 months of age may have such distress from the wheezing and labored breathing, they can't drink.

Children with bronchiolitis may need to be admitted to the hospital so oxygen and intravenous fluids can be given. Since this infection is caused by a virus, antibiotics don't have a direct benefit. Secondary ear infections or pneumonia can develop. In which case, antibiotics serve a valuable purpose.

In limited situations, an antiviral drug called Ribaviran™ may be used just for RSV life-threatening infections. It is not recommended for most cases of bronchiolitis, since most children do well and are not bothered by the severe cough or it's complications.

It may difficult to differentiate RSV from asthma-like illnesses and in some cases asthma medications are tried.



## Medications and drugs

### Antibiotic medicines

Instructions to parents I may prescribe an antibiotic medication for your child's infection. Treatment requires special care to help avoid unwanted after effects. The antibiotic will help cure the infection when taken regularly for the time stated on the prescription. It may not seem necessary to continue giving antibiotics when your child feels well after just a few days. I urge you to give the full dose each day for as long as is stated on the prescription. Report to me if severe diarrhea develops or a skin rash appears. These signs may be due to the effects of the medication. Mild diarrhea can occur with some antibiotics and no special attention is required if your child tolerates it well. Use extra Vaseline™ or Desitin™ creams on his or her bottom to shield the skin from harsh stools. Avoid extra dairy products and fruit juices if there is much diarrhea (*see Diarrhea...*).

Give the antibiotic medicine the number of times per day prescribed during the hours your child is awake. Space the doses out evenly. Use a medication spoon for liquid medications to ensure an accurate dose is given. Kitchen spoons are sometimes inaccurate. The medication may be given at the same time as other medications. If the antibiotic is a liquid, store it at the back of the refrigerator, out of reach. Shake the bottle well before giving the dose to make sure it is mixed well. This can be very important because the favoring can settle and your child won't receive the medication in even doses, causing side effects or worse, no effect on the infection.

If there is fever, aspirin free medications can be used along with the antibiotic. It may take 1 or 2 days to see definite results so Tylenol™ may need to be continued even after starting treatment with other medications. Report back to the office if you have seen no improvement in about two days or you believe your child has gotten worse.

If a return appointment is recommended, please keep the appointment.

I may need to make sure no further treatment is necessary. Unfortunately, some infections don't clear up completely but your child may seem well for days before symptoms become apparent. Do not give antibiotic medicines away to family, friends or relatives to give to their children. Partial treatment may initially hide but not cure a serious infection that could damage or kill another child. After giving the antibiotic for the full time prescribed, you should throw away the remaining amount, unless I instruct you differently.

---

### Medication dosing

When I was updating my pediatric office manual *Notes and Tips*, "the I realized that I was missing one important topic for my patient's parents — medication dosing. I wrote about the subject a long time ago, and I wanted to go over it again for new parents.

Many OTC or over-the-counter medications are available now that were prescription only a few years ago. Some examples would be hydrocortisone creams, Actifed, Benadryl, Claratin, and the list grows. The problem for parents is that the labeling tells the parent to call the doctor for children 2 and under. That is a major problem when most of the sick kid calls we get are for the very young child.

To help save you time and confusion, these are guidelines for you.

You can *always* give Tylenol™ or acetaminophen products with cough and cold medications, asthma medications, or antibiotics. In fact, you can give any of these medications together. Old package inserts still might counsel against giving cold medications for asthma patient, but my experience and modern theory indicates it is very safe to combine all the ingredients.

A safe rule of thumb for average size children is you can give over the counter medication in these amounts: 3 months =  $\frac{1}{4}$  tsp., 6 months =  $\frac{1}{2}$  tsp., 9 months =  $\frac{3}{4}$  tsp., and 12 months = 1 tsp. I usually follow 1 tsp. Per 20 lbs. Of body weight (do not exceed 3 tsp.).

Common side effects of these cough-and-cold medications are either sleepiness, or hyperactivity or irritability. You can adjust the dosing up or down according to the side effects. For example, if your child is too sleepy decrease the amount by  $\frac{1}{4}$  to  $\frac{1}{2}$  tsp.

Most cough-and-cold medications work more effectively for allergic illnesses like hayfever. Colds don't respond dependably to any prescription or nonprescription cold medication.

Antibiotics, asthma medications, or any other prescription medication will have the dose written on the bottle label. You are to follow the dose exactly as written on the label. If you ever believe the dose is too great or too little, you must notify the pharmacist or me as soon as possible.

For Tylenol™ or Motrin dosing refer to my Table in this manual.

---

### Aspirin, Tylenol™, or Advil™

There are so many products in the stores, and so many claims by the manufacturers. Which product should you use? What is the difference?

Aspirin, Tylenol™, and Advil™ are actually three different drugs. Aspirin is the generic name for a drug that has been used for many years.

It is so well recognized, parents often say aspirin when they mean a different drug like Tylenol™.

Aspirin use in children has declined in recent years. Pediatricians were concerned about the many poisonings from aspirin each year and began recommending the safer drug, Tylenol™ or acetaminophen when it became available. Poisonings from aspirin are rare, because of safety caps and reduced use.

Aspirin is still an important drug that effectively lowers fever and controls pain. Because it works no better than Tylenol™ for these two conditions, I recommend you use Tylenol™ as your first choice. One advantage of aspirin over Tylenol™ is its anti-inflammatory drug properties. Aspirin works better for injuries or for arthritis, reducing swelling and inflammation. It is a very safe drug and reactions beyond mild stomach upset are unusual. Do not use aspirin if your child has a cold or "FLU." A rare condition called Reye's Syndrome is associated with aspirin use and can cause serious disability or death.

Tylenol™ or acetaminophen is an excellent pain reliever and is good at lowering a fever. Even though Tylenol™ must come with a child-proof cap, accidental poisonings from an overdose are rare because the drug is tolerated in larger amounts without side effects.

Recently, Ibuprofen, or Advil became available without prescription. In large doses, it has some of the same undesirable side effects as aspirin. It is safe enough to take without the danger of undesirable side effects. Ibuprofen also has good pain relieving properties. Unlike Tylenol™, it does have the anti-inflammatory effects of aspirin and can be used instead of aspirin. Recently, some studies showed the safety and effectiveness of using Tylenol™ and Ibuprofen together to lower the temperature in children who were very uncomfortable and not helped by Tylenol™ alone. Currently, Ibuprofen liquid is available only by prescription. I use it sparingly for two reasons. Tylenol™ is safer and just as effective for minor fever or pain. I don't believe fever is a serious problem for most infants and children. By encouraging parents to use fever lowering medications, I pass on a wrong message — worry about fever. When a children or infants is very uncomfortable, these medications can be safely used. Medications are not necessary for happy, content children with fever. Instead, dress them lightly and encourage fluids. (*See section on fever*)

## Miscellaneous

### Pain therapy

In this topic I write about Tylenol™ use. Some of the following comments are regarding pain management .

If your child seems to be in pain for any cause what do you do? Surprisingly, many parents do little or nothing. I am not sure why. Some parents says that they are worried that they will treat pain when none exists. I say, “So What.”

If there is a pain, how do you help your child feel more comfortable? Some parents use a reassuring voice. Some parents use a reassuring caress. Some parents use medications like Tylenol™. Some parents call the doctor. Probably the least effective method to relieve pain will be a phone call to the doctor. Even if you know the cause of the pain, help your child feel as comfortable as you can. Helping relieve your child’s pain will not complicate matters.

How can you tell if your child is in pain? Even within a few days to a couple of weeks most parents can recognize a painful cry from a tired, mad, or lonely cry. In time you recognize body positions, facial expressions, sounds, and behavior. When these conditions last more than 5 or 10 minutes you should do something, even if it is to only acknowledge that you believe they are in pain.

I know that calls to the doctor might relieve parental anxiety —parent-feeling-for-the-child pain. Of course, a call might help determine if the pain requires physician attention and action. Take some action to relieve the pain first, and if the pain persists or is reoccurring then a call to the doctor’s office is in order.

Let me re emphasize. Even if you know that the pain was caused from an injury, illness, teething, or stress, it is always safe to give Tylenol™.

Before I leave the subject about pain relief and the use of Tylenol™ or other over-the-counter pain relievers, let me answer another common parental concern. Parents worry that if they use Tylenol™ too frequently when their child complains about pain or appears to be in pain, they will develop some dependency or do harm. There is no evidence that if you use aspirin-free medications like Tylenol™ as recommended that your child will develop any addiction or dependency even psychologically.

When your child has relenting pain, reoccurring pain, or pain that interferes with normal activity or sleep, you should call my office.

Everyone will experiences pain at one time or another. There is no harm in allowing yourself the opportunity to lessen it, if possible.

---

### Infant sleeping position

Parents and care givers might consider placing healthy infants on their sides or backs when putting them down to sleep. Recent studies suggest that there might be an increased incidence of Sudden Infant Death Syndrome in infants who sleep on their stomachs. There is no information that sleeping on the back or sides is harmful to normal infants.

There are some infants who should be placed on their stomachs when they sleep.

- 1) Premature infants with severe breathing problems
- 2) Infants who have problems with severe spitting up or vomiting
- 3) Infants with certain abnormalities of their upper airway

There might be other reasons for infants to be placed on their stomachs for sleep. You should discuss your particular concern or circumstances with me.

Even though there might be an increased risk for SIDS for some infants who sleep on their stomach rather than on their back or side, the real risk for SIDS for children sleeping on their stomach is extremely low. If that is the most comfortable position for them or the one they return to, don’t be alarmed.

---

**Family Resources**

**Valley Health and Support Organizations**

**Support Groups (These numbers might not be current – check with information)**

(Check the telephone book before dialing because these numbers might not be current)

Adolescent Support Group, 221-8874

Adult Children of Alcoholics and Adult Children Anonymous, 449-9107

Adult Survivors of Incest, 435-8402

Alcoholics Anonymous, 221-6907

All About Support Groups, 222-9471

Arthritis Support Group, 264-2013

Battered Women's Support Group (YWCA Program) 237-4706; 24 hour line, 237-47

Brain Tumor Support Group, 449-2000

Breast Cancer Support Group, 449-5333

Breast Implant Support Group (San Joaquin Silicone Survivors), 798-1747

Caregiver Support Group. 449-3626

Co-Dependency Group, 248-1548

Co Dependents Anonymous, 222-2066

Compassionate Friends (for parents whose children have died), 229-1388 or 23

Depression, Therapy/Support Group, 266-2694

Diabetes Support Group (Take A Break), 298-7103

Diabetes Support Group (for Latinos), 298-7103

Fibromyalgia Support Group, 348-9268 or 298-0878

Family and Friends of HIV+, 264-2437

Gamblers Anonymous, (800) 522-4700

The Gift of Life Family Support Group, 497-8328, 233-CARE

Grief Support Group, 449-5600

Neuro-psychological Trauma Head Injury Victims Support Group (for adults recovering from mental health problems), 486-1770

Healing for Survivors of Sexual Abuse Support Groups, 442-3600

Huntington's Disease Support Group, 225-6748

Impotence Support Group, 449-5333

Incest Victims, (800) 422-4453

La Leche League of Fresno Support Group (breast-feeding mothers), 291-0490

Lactation Support Group, 449-5210

Life After Loss Support Group, 449-2000

Lupus Support Group (Fresno), 227-5836

Manic-depressive Illness Support Group, 297-1041

Mastectomy Support Group, 449-5333

Moms Support Group, 449-5210

Mothers of Sons/Daughters lost to or living with HIV/AIDS, 222-9471

Moms Support Group, 449-5210

Mothers of Sons/Daughters lost to or living with HIV/AIDS, 222-9471

Muscular Dystrophy Support Group, 221-6991

Narcotics Anonymous, 255-5881

Nar-Anon, 275-1692

Pills Anonymous Support Group, 449-8000

Post-Polio Support Group, 438-4136 or 229-2107

Prostate Cancer Support Group, 449-5333

Pulmonary Support Group, 221-5634

Sexually Free Support Group (for men struggling with sex addiction), 227-1066

SHARE (for parents who have lost a child), 449-5210

Spinal Cord Support Group, 442-6414

Stress and Depression Support Group, 294-7178

Survivors of Sexual Abuse, 294-7178

Survivors of Suicide, 435-7669

Torticollis Support Group (neurological disorder), 299-1579

Valley Parkinson's Support Group, 227-3048

Victims of Violent Crime Support Group, 294-7178

**Other Help Organizations:**

AIDS Testing, 445-3434

Adults with Mild Developmental Disabilities, 488-1103

African-American Outreach Project (parents of special needs children), 229-2000

Alcoholism and Drug Abuse Council, 248-1548

Alisa Ann Ruch California Burn Foundation (San Joaquin Chapter), (800) 242-2876

Alzheimer's Association (Fresno/Madera Chapter), 229-2891. Support Groups  
co-sponsored with: Alzheimer's Disease Center, 233-3363; Clovis Senior Cent  
297-2480; Madera Rehab/Convalescent Center, 673-9228; Valley Caregivers  
Resource Center, 225-6748.

Alzheimer's Disease Education and Support Groups, contact Mary Parsons; 233-7041  
Kerman Senior Center, 846-8643; Madera, 675-3119; Oakhurst, 642-3806; Merced  
358-5581; Coalinga, 935-5001.

American Cancer Society, 243-0112.

American Diabetes Association (ADA), 298-7103

American Lung Association, (800) 586-4872 or 222-4800

American Red Cross (Fresno/Madera Chapter), 486-0701

Arthritis Association, 264-2013

ARC (Association of Retarded Children), 291-0611

Autism Society of America, 227-8991

Better Breather Club, 222-4800, (800) 586-4872

California Association of the Physically Handicapped, 267-6777

California Eye Institute, 449-5000

California Eye Institute, 449-5000

Center for Independent Living of Fresno, 276-6777

Central Valley AIDS Team, 264-2437

Christian 12-step classes, 432-8419

Community Hospice, 221-5608

Community Health Education, 221-5628

Consumers Against Abusive Health Care, 265-6677

County Mental Health Program, (800) 359-6939; Madera Clinic, 673-3508; Oakhurst Clinic, 683-4809; Yosemite Women's Center, 661-0296

Domestic Violence, 486-8451

Eating Disorders Treatment, 486-8451

Economic Opportunities Commission Tobacco Education program, 263-1265

Epilepsy Foundation of Central California, 490-1414

Exceptional Parents Unlimited (EPU/Down Syndrome referrals), 229-2000

Footsteps, 449-5600

Fresno Area Auxiliary of the Myasthenia Gravis Foundation California Chapter (neuromuscular disease), 291-3725

Fresno County Alcohol And Drug Advisory Board, 445-3272

Fresno County Commission on Alcoholism (for Spanish-speaking), 268-6475

Fresno Mayor's Committee for Employment of People with Disabilities, 486-7332

Fresno Auxiliary of Northern California Chapter of National Friendship Center of the Blind, 266-9496

Hemophilia Foundation, 291-3970, 224-2368

Hospice of Fresno (Saint Agnes), 449-5600

Inflammatory Bowel Disease (IBD), 449-2000

Look Good Feel Better, 243-0112

Lost Chord Club of Central California, 237-1540

Mended Hearts (heart patients), 224-4647

Metro Program (Drug and Alcohol), 268-6475

Multiple Personality Disorder Group, 221-8874

National Multiple Sclerosis Society, 226-2005

Panic Anxiety Self-Help Group, 237-8304

Phobia Treatment Program, 294-7178

Rational Recovery (self-help group for alcoholism), 294-1366

Self-Help for the Hard of Hearing, 434-6141

Take Off Pounds Sensibly, 222-8434

Total Awareness Head-Trauma Center, 488-1103 or 486-1770

United Ostomy Group, 449-2000

Valley Caregiver Resource Center (serves the care giver of a brain-impaired adult), 447-2140; Hanford, (800) 541-8614

### **Men's Issues**

Magnet Couples for mixed HIV status gay male couple, 264-AIDS

Man to Man, for Gay/Bisexual men, 264-AIDS

Men's Awareness Group, 248-1548

Men's HIV+ Therapy Group, 264-AIDS  
Men's Issues Support Group, 625-1523  
Men's 12-step Awareness Group, 248-1548

United Ostomy Group, 449-2000

Valley Caregiver Resource Center (serves the care giver of a brain-impaired adult),  
447-2140; Hanford, (800) 541-8614

### **Youth Organizations**

Adolescent Support Group, 221-8874  
Foster Friends, 237-8304  
Children Whose Parents Have HIV/AIDS, All About Care, 222-9471  
D.A.R.E. (Drug Abuse Resistance Education, 488-3383  
Disabled Student Services (CSUF Volunteer Book Readers), 278-2903  
Disabled Students Program and Services (for students with physical and/or learning disabilities), 442-8237  
Comprehensive Youth Services, 229-3561  
Childhelp Independent Order of Foresters, (800) 422-4453  
Children's Group (5-11 years), 248-1548

### **Women's Issues**

Battered Women's Support Group (YWCA program) 237-4706; 24 hour line, 237-4701  
Breast Cancer Support Group, 449-5333  
Breast Implant Support Group (San Joaquin Silicone Survivors), 798-1747  
Breast Cancer/Reach To Recovery, 243-0112  
Breast Cancer/Volunteer Visitors, 243-0112  
Breast Feeding Clinic, 449-5210  
La Leche League of Fresno Support Group (for breast-feeding moms), 291-0490  
Lactation Support Group, 449-5210  
Menopause Support Group, 449-2000  
Rape Counseling Service, 497-2900  
Relationship Issues Group, 222-0146  
Remarried Couples Group, 221-8874  
Women for Sobriety Support Group (for women concerned about their drinking),  
561-3266  
Women's HIV+ Therapy Group, 264-AIDS  
Women's Support Group (for women with HIV/AIDS), 222-9471  
Women's Support Group (Clovis), 294-7178  
Remarried Couples Group, 221-8874  
Women for Sobriety Support Group (for women concerned about their drinking),  
561-3266  
Women's HIV+ Therapy Group, 264-AIDS  
Women's Support Group (for women with HIV/AIDS), 222-9471  
Women's Support Group (Clovis), 294-7178  
Women's Therapy Groups, 227-7086  
YWCA Marjaree Mason Center (domestic violence), 233-4357

### **Sexuality**

Adult Survivor's of Incest, 435-8402

Magnet Couples, for mixed HIV status gay male couples, 264-AIDS  
Man to Man, for Gay/Bisexual Men, 264-AIDS  
Survivors of Sexual Abuse, 294-7178  
Sexually Free Support Group (for men struggling with sex addiction), 227-1066

### **Veterans**

Chapter No.1 Disabled American Veterans and Service Office, 485-3281  
Disabled American Veterans Thrift Stores, 701 Van Ness Ave., 237-0273; 2421 E. Clinton Ave., 229-2380  
Fresno Veterans Center, 363 N. First St., 487-5660  
Veterans Administration Medical Center, 2615 E. Clinton Ave., 225-6100  
Veterans Crisis Programs, 128 Yosemite Ave., 266-4950  
VFW Post 8900, 3585 N. Blythe Ave., 275-4061

---

### **Teething and fever**

This question comes up so frequently and persists no matter what. Teething never causes a temperature of 101° or more. Teething is a natural process before a tooth emerges and drooling and chewing are noticeable from infancy. During these first two years, infants and toddlers are continually exposed to infections (usually viral). There is a natural coincidence of events because they both appear about the same time. It is understandable why parents connect them. If a fever is present when you teethe, it must be the teething causing the fever? Wrong! If your child has a temperature of 101° or greater, your child has an infection. If that fever last more than a couple of days call during office hours so we can arrange an exam to rule out a treatable cause.

---

### **Irregular heart beat**

Parents might notice an irregular heart beat in their child. Usually, you or your child will be unaware of irregular beats.

In the newborn period the atria of the heart can be the source of the unrhythmic beat. (This is one of the two smaller chambers of the heart.) These nonsynchronous heart beats don't signify any heart disease and will disappear within days or weeks. I will pick up this irregular beat during the newborn exam and evaluate the heart with an electrocardiogram. The EKG is read by a pediatric cardiologist. If the baby has no symptoms I will observe and wait for it to disappear. Consultation with the cardiologist is necessary when symptoms of persisting cough, poor feeding or blue lips and face are noticed.

The second occasion for an irregular beat is during middle childhood. The child or you fortuitously notice a skipped heart beat. This is called a sinus arrhythmia (irregular heart beat). It is a rhythm change with a normal breath. The beat speeds up while breathing in. To test this the child holds his breath and the rhythm continues normally, but a breath breaks up the rhythm and a skipped beat is detected. This is harmless and can be ignored unless symptoms of shortness of breath or unexplained cough appear.

Another situation when an irregular beat is detected is during older childhood, adolescence or as a young adult. The child or adolescent notices an irregular beat while at rest. It is startling for them and they will show concern. The only symptom is anxiety although the adolescent may be matter a fact about the irregularity. There should be no chest pain, shortness of breath or fatigue. There may be no obvious cause, but commonly use of too much caffeine can be a trigger for the arrhythmia. Other factors can be emotional stress, stimulants, smoking, medications and illegal drug use.

---

### **Nintendo or Sega disease**

Nintendo games are tremendously popular with young children and adults, but, occasionally, some side effects appear. Medical journals have received letters from doctors describing different disorders caused by excessive Nintendo playing.

One conditions associated with game playing is over-use injuries to the muscles, ligaments and tendons from over-use. Fingers and thumbs can develop tendonitis from repetitive pressing and releasing control buttons. When complaints begin, parents should establish a "time-out." Rest will improve and correct most problems. A few hours up to a few days can be needed. If pain is intense or swelling occurs, start with Tylenol™ or aspirin. A similar problem can be seen with neck or shoulder strain from holding the controller and cocking the head upward to see the screen. You can correct this by having your child sit farther back and resting the controller on a pillow or table.

Other problems such as loss of sleep and nightmares don't appear to be associated with Nintendo game playing. A competitive child will become agitated from repetitive trials and failures. Examine the game and try to determine if it is designed for your child's age group or find a substitute game that can be more easily mastered.

One doctor described a child's problem with fecal incontinence. The youngster was withholding the natural urge to go because he or she did not want to leave the game. The solution was to remind the child about the "pause" button and emphasize its use.

One problem with Nintendo games is few learning programs exist. This, will probably be overcome as developers of software try to compete with Personal Computers from Apple, IBM, and Atari. Nintendo games do give children a chance to develop eye-hand coordination. Memory skills are necessary in order to avoid past pit-falls and advance farther into the game. My advice is to ration Nintendo time as you might TV viewing time. Fresno days are generally perfect for outdoor play. Cardiovascular exercise is important for all ages. Nintendo games are not bad, if the preceding suggestions are followed.

---

### **Baby sitting reminders**

As I was tossing out old notes and papers, I noticed one of the American Academy of Pediatrics flyers on parent safety tips when they leave their child(when) with the baby sitter. I want to pass on some of their guidelines.

The first suggestion is to show the sitter important phone numbers to call in case of an emergency. These numbers or some that you believe are useful include: Neighbor, Physician, Fire or Paramedic (911), Police and Poison Control. Also consider the number you can be reached at or a number where you check in periodically, if you travel.

Parents should: Check the baby sitter's references, training and general health in advance. Allow the sitter to spend time with you before "sitting" to become acquainted with the children and their routine. Show the sitter around the house pointing out fire escape routes and potential problem areas. He or she should be instructed to leave the house immediately in case of fire and call the fire department from the neighbor's house. You need to discuss feeding, bathing and sleeping arrangements for the children. Leave a flashlight. Tell the baby sitter where you can be reached and the hour of your return.

Always phone for help whenever you are concerned or in doubt. Never open the door to anyone who has not been cleared by the parents. Never leave the children alone in the house-even for a minute. Never give any medicine or food unless instructed to do so. Always remember your primary job is to care for the children. Tender loving care usually quiets an unhappy child.

---

### **Poisoning**

Children almost always swallow poisons accidentally.

Most poisoning can be prevented. Keep all potentially harmful substances out of reach. Medications, insecticides, caustic chemicals, cleaners, fuels and polishes are dangerous. Drain cleaners are very dangerous. They are strong alkali materials that destroy the lining of the mouth, throat, stomach, and intestine when ingested.

Treatment must be rapid to be effective. It is most important to determine the chemical your child swallowed or was exposed. Call my office or the *Poison Control Center at 445 1222* as soon as possible. I can direct you as to the best course of action. Try to find out the name or type of poison. If you are heading to the emergency room, bring the container of the suspected poison with you.

Teenagers may attempt suicide by taking overdoses of common medications. All suicide attempts should be considered a call for help. Even if the drug does not seem harmful or the attempt is thwarted, follow-up is essential. Successful suicides are often preceded by unsuccessful attempts.

After a potential poison is swallowed, treatment at home may require vomiting to remove the substance before it does damage. Vomiting can complicate care or recovery. Movement up and down the esophagus can re-expose the lining to the caustic solution or increase the chances it will be inhaled into the airway. Milk or water may be needed. Never start treatment without consulting me or the or *Poison Control Center* first.

Vomiting is a safe way to remove some substances, safer even than “pumping” the stomach. Syrup of ipecac is a safe way to induce vomiting. It is essential to keep 1 to 2 ounces at home when you have children under 4 years of age in the household. One tablespoon should be followed by as much water as possible. If there is no vomiting within 20 minutes after drinking the Ipecac, you should give another tablespoon. Unfortunately, children who accidentally ingest poisons are more likely to ingest poisons again in the future.

Potentially dangerous poisoning is best managed in Valley Children’s emergency room. Children who are conscious will be treated differently than unconscious children. If your child is unconscious or is not aware of his or her surroundings, bring them to the emergency room immediately.

## Muscles and Bones

### Hernias

Hernias are common in early infancy and throughout childhood. Frequently I am asked to evaluate the presence of a hernia and the necessary course of action for the parent and child.

Hernias occur when a loop of intestine or structures associated with the intestine protrude through the wall of muscles of the abdomen, scrotum, inguinal area and other structures. The earliest hernia most parents notice will be the umbilical hernia. The umbilical cord or remaining stump, “Belly Button”, appears to bulge outward. Sometimes, this is barely noticeable, but some hernias will protrude an inch or more and cause concern for the parents. It looks unsightly and some parents wonder if loops of bowel will be trapped inside. Very rarely will any umbilical hernia be complicated. Yet, it may persist for up to three years. No



treatment is needed, although I notice some ethnic groups putting coins, straps or belts over it. These devices have the potential to cause more harm with little good. Do not try to force this umbilical hernia inward. It does not work to help heal or restore the hernia to normal.

A second type of hernia is the inguinal hernia. Parents may notice during bowel movements, laughing or crying, a bulge appears in the groin area on one or both sides. The bulge might return to normal or flatten out or it could persist. There will be no pain or discoloration at the site of the hernia. Pain or discoloration are more serious signs and warrant an immediate call to my office. This type of hernia is seen in infancy through adolescence. Unlike the umbilical hernia which improves and disappears over time, the inguinal hernia needs to be repaired at some point. I always refer these to a pediatric surgeon for assessment and recommendations. Surgery is often an outpatient procedure with a quick return home the same day. *Last reviewed 7/16/07*

---

### Bowlegs and knocked-knees

During normal development, children are bowlegged and then knocked-kneed. Special shoes or wedges make no difference.

I will advise if your child’s bowlegs or knock-knees are normal conditions or if treatment is required. If the condition is normal, time is the best treatment. If your child’s condition is severe or one-sided or even runs in the family. Severe deformities will need the assessment of an orthopedic surgeon to decide if surgical correction will be necessary.

---

### Flatfeet

Flatfeet are normal in infants and young children. The arch develops whether your child wears shoes or goes barefoot. Special wedges, inserts, or heels are not necessary for the normal toddler with flexible flatfeet. One in seven children never develops an arch. Children usually have low arches because they are loose-jointed. Their arches flatten when they are standing, and can be seen when their feet hang free or they stand on their toes. Normal children are different heights, so naturally, the height of their arches will be different. Earring pads or wedges under the arches can make children uncomfortable and probably is a waste of money in most cases. I am concerned when your child’s flatfoot is stiff, painful, or if your child has high arches.

---

### Pigeon toes

“Pigeon Toes” describes toes that point inward or outward.

In-toeing is quite normal in early childhood and it is usually outgrown. There are three forms of in-toeing. The first is sometimes called hooked foot because the foot appears to be shaped like a “C”. It is caused by the position of the baby before birth. Most hooked or curved feet get better without treatment during the first year. I will examine your child’s foot to

determine if it can easily be molded to a straight position. If not, I will refer your child to an orthopedist who will determine if a cast is necessary.

---

### **Tibial torsion**

Tibial torsion results when the normal process of leg rotation, from a confined position before birth to a more turned-out stance, is prevented by the child's sleeping position. The tibia is the larger of the two bones between the knee and the ankle. Torsion refers to a natural twisting of the bone as your child grows. I often ask parents about the child's sleeping position when I take your child's medical history. Tibial torsion usually gets better without treatment. If the torsion or twisting is severe, the twisting can be improved by forcing a change in the usual sleeping position of the feet. This can be done by tying tennis shoes with a shoe lace or sew the sleeper or PJ heels together. A splint or hard metal bar connecting the shoes can also be used.

This last device was commonly used by older generations until we realized time corrected the problem without more drastic procedures. Many grandparents and older parents still tell me about their experiences.

---

### **Femoral torsion**

Femoral torsion is a twisting of the largest leg bone or femur. I can easily spot this when the child sits and I see the knee caps facing inward instead of straight forward. The cause of this condition is unknown, but I frequently see children with femoral torsion sit on their buttocks with their legs pointed outward and their feet pointed inward. Femoral torsion is usually most severe when the child is about 5 to 6 years of age, and fortunately, children outgrow this condition. Shoe modifications and braces do not work for femoral torsion. They can make the child uncomfortable, self-conscious, and hamper play.

---

### **Growing pains**

Complaints about growing pains are common in the 3 to 5 year old and the 8 to 12 year olds. Girls seem to be affected more than boys. Headaches, stomachaches and leg aches are common symptoms. Your child may be free of pain for days, weeks or months in between periods of pain. The complaints come at the end of the day or during the night. The pain causes cramps, creeping sensations or restless legs. There is no redness, swelling, decrease in motion of the joints, limping or local tenderness. Exams are normal — physical, X-ray and laboratory. "Growing pains" disappear after 1 to 2 years.

Growing pains has nothing to do with growing since they occur at a time when the growth rate is less than in earlier years. They probably are caused by increased activity and exaggerated stretching.

It has been shown that when parents help with passive leg stretching twice a day, the problem resolves itself more quickly than if no treatment is given.

Several conditions referred to as "growing pains" cannot be included in this category. Conditions I will consider are : flexible joints, chronic knee conditions, nighttime leg cramps, non cancerous bone tumors, and psychological conditions. While these conditions are not serious, they should be treated differently than "growing pains."

---

### **Patellofemoral syndrome**

This is one of the common causes of knee pain. It is a pain that is vague in the knee area. There is not connection between any event or trauma.

Climbing stairs or sitting for a long period aggravates or provokes the pain. Special exercises, knee bracing, and anti-inflammatory drugs might be tried.

---

### **Knee pain**

Knee pain is one of the most common complaints from young adolescent athletes. Fortunately, most of the causes for the pain are not serious and respond to conservative medical management. It is my job to ferret through the history and the exam to determine the serious and the not-so-serious.

Uncommon or rare problems range from benign and malignant tumors of the bones, injuries to the hips, causing pain to radiate to the knees, or types of arthritis. More common problems involve injuries to support structures of the knees, stress injuries of the knees, and congenital malformation of the knee cap.

The most common injuries of the knee are “jumpers knee”, Osgood-Schlatter’s disease, and Patellofemoral syndrome.

“Jumpers knee” causes pain over the center of the knee. The pain develops gradually. In most cases your adolescent won’t remember any specific injury that produced the pain. Jumper’s knee occurs in those who participate in these sports: basketball, volleyball, track and field, tennis, ballet, and long distance running. The injury can be rated from 1 to 3 severity. A grade one injury will respond to very conservative treatment. A grade three injury might require surgery.

1. Grade one is pain only after the exercise.
2. Grade two causes pain during and after the injury, but the adolescent can continue without any decrease in normal activity.
3. Grade three has pain during and after the activity, and is unable to complete the activity as before.

Osgood-Schlatter’s disease causes pain just below the knee-cap in an area called the tibial tuberosity. This area becomes tender and swollen. Bending the knee produces more pain. Usually rest for 6 to 8 weeks will be adequate while the tendon heals. In some adolescents the swelling persists for months and eventually might produce hardening or calcification and a hard protrusion. An elastic pad might be recommended or a brace to protect the area and restrict bending of the knee. This condition resolves completely after the adolescent’s growth spurt stops.

---

## **Scoliosis**

You have heard about some children who have an abnormally curved spine or know relatives or friends who have back problems since clatter childhood. These people might have a condition called scoliosis

The lateral spine sometimes curves abnormally to the side. This can cause an s-shaped curve instead of the normal straight line of the back. Most people will have one shoulder slightly higher than the other, the leaning dependent on which side is your dominant side — right sided equals right handed. In a person with scoliosis one shoulder will be dramatically tipped to one side. In most cases we don’t know the cause of scoliosis. In girls scoliosis seems to predominate. Scoliosis also seems to appear more frequently in certain families. If I become aware a close family member has scoliosis (for example, the mother), I will keep a close on the children. Many parents believe that poor posture will cause permanent damage to the spine, but there is no evidence scoliosis is caused by poor posture. The exception would be in persons who have damage to the muscular system or nervous system and do not have normal muscle tone.

If I detect an abnormal curve in the spine I will ask you contact an Orthopedist to measure the curvature of the spine and make recommendations for treatment.

Treatment may not be necessary in some children or adolescents. I may follow them every 3 to 6 months during the faster growth periods. If there is a dramatic change a brace is indicated in certain cases. In other severe conditions, surgical bracing or repair might be necessary.

## Nervous System

### Headache

More than 40% of all children have had a headache by the age of seven, and 4% of seven year olds are troubled by frequent headaches. By the age of 15, 75% of children will have a headache and 20% will have headaches frequently.

An isolated headache may be due to an earache, sore throat, tooth ache, or eye infection. Even young children may suffer from sinus infections. Serious infections may cause severe headaches along with stiff neck, vomiting, fever and irritability. Meningitis is an important consideration and requires immediate attention by our office or Children's Hospital emergency room.

Stress must be considered even in younger children as the cause of headache. Five year olds can be effected by stress and tension. Older children have stress as the primary cause of headache. Constant tension on the muscles over the head and along the neck produce a substance causing the pain. Tension headaches can occur in any part of the head with a slow developing dull, full feeling, or pulsating sensation. Headaches may be the first symptom of stressful problems at school, at home or with friends. A child who is functioning poorly in any of these areas may need help.

Many medications, including decongestants and antihistamines can cause headaches. Headache is common just before menstruation. Eyestrain is often blamed but is seldom a cause of headache.

Migraine or vascular headaches often start in childhood. Some toddlers who vomit may have migraine. As they are grow older and are able to communicate more understandably, headache may be recognized as the precipitator of the vomiting. Children with migraine often have at least two of the following : 1) headache on one side only, 2) nausea, 3) visual changes before a headache, 4) other family members with a migraine headache history. These headache are often throbbing in character and begin quite quickly.

Headaches may be the only sign of a seizure. These headaches begin suddenly and are followed by a period of drowsiness or sleep.

Many parents are concerned about brain tumors. Headaches associated with brain tumors are usually persistent and worsening. Headaches may awaken children or persist into the morning. I become most concerned when headaches are associated with difficulty with walking, personality changes, weakness in arms or legs, changes in vision or speech, and vomiting. Fortunately brain tumors are rare in children and these symptoms are brought on by other conditions.

The first treatment you may consider is diversion, support, and reassurance. Most headaches disappears in a couple of minutes. When headaches persist disturb sleep or activities you can always safely use aspirin free pain relievers like Tylenol™. If hayfever is suspected as the cause of the problem, antihistamine, decongestant combinations found over the counter work well. Persistent or reoccurring headache may need medical attention especially if associated with other physical signs. *Last reviewed 7/16/07*

## Newborns and Babies

### Baths

Sponge baths should be given as needed every one to two days until the cord has dried and fallen off. Use only water for the first few days and then substitute a mild soap like Dove™. Room temperature should be above 68 degrees. Dry the skin by patting with a towel. Do not use any oil, powder or lotion. This will slow the natural shedding of older skin that occurs for the first several weeks. Your baby was suspended in amniotic fluid for nine months and has to shed multiple layers of skin that were in contact with the fluid inside the uterus.

---

### Navel (umbilical cord)

Cleanse the base of the navel with a cotton ball dipped in rubbing alcohol each time you change the diaper, until it has dried and fallen off. Apply enough pressure to the skin around the cord to view the base below the drying tip of the cord. Disposable pads and Q-tips will not contain enough alcohol so avoid these. No binders or pads are necessary. Some bleeding normally occurs as the cord detaches from the navel. It might take a couple of weeks or more to fall off. [Image available]

Contact me if there is a large amount of bleeding.

---

### Sleeping

Babies sleep in many different positions. As they grow, they will let you know their preferences, but **the preferred position is on their back**. Newborns are usually placed on their backs or sides to help reduce the possibility of choking. This position is helpful if they have lots of mucus in their throats. The baby's mattress should be flat and firm with a water proof cover to protect it. DO NOT use pillows because of the danger of suffocation.

---

### Stools

Your baby may have a bowel movement after each feeding or may have only one or two stools a day. Some babies go 48 hours or more without a bowel movement. This is normal. Your baby may strain when passing a stool, but unless the stool is hard and pellet-like, this is perfectly normal. Stools may be mushy, or watery for many weeks. Blood is NOT normal. Blood can color the stool bright red or turn the stools black. Breast fed infants usually have more frequent stools than formula fed infants. The breast fed infant's stools can range from pea soup to lemon custard with cottage cheese lumps.

---

### Babies are babies

All babies sneeze, yawn, hiccup, pass gas, cough, and cry. They may occasionally look cross-eyed. Although they are able to recognize shapes and faces early, they have difficulty focusing on objects.

The widened bridge of their noses also gives the appearance of eye crossing. Sneezing is a major way for a baby to clear its nose of mucus, lint, or milk curd. Hiccups are normal. They are caused by immaturity of the swallowing center in the brain. Hiccups can be stopped by giving a few swallows of water. Coughing is one way the baby may clear its throat. Crying is a baby's way of saying, "I'm hungry, I'm thirsty,

"I'm wet, I'm cold, I have a stomach ache or I'm bored." You will gradually recognize which cry means what. Even well babies can cry for an hour or more during the day without doing any harm. You may find your baby cries more at one time of the day than any other time. Many parents say their babies cry in the afternoon and early evening most frequently.

---

### Books and resources

To help you with other problems you might have with your child, some good resources at the book store are :

“Baby and Child care” by Dr. Benjamin Spock  
“The First Twelve Months of Life” Frank Caplan, Grossett & Dunlop, Publishers  
“Infants and Children” by T. Berry Brazelton, MD  
La Leche League International

Barnes and Noble and Borders have many, many. Pick the one that reads the best for you. When I first wrote my manual the Internet wasn't in the form it is today. I will remind you that through my Web site you have access to lots of good health information.

There is no definitive book for parents (*except this one, of course*). One style of writing or approach to solving problems may appeal to you more than another. Dr. Spock has served parents well over the years because his books are comprehensive and time tested. Consider purchasing at least two books on children: One to cover common illnesses. The second book to cover development and behavioral issues. If you can't find information about a problem that concerns you, call me at the office. If I don't have the answer, I will find the answer or direct you to a helpful source. I have many useful handouts. Many other experts have written excellent books. But, there is so much information, it is impossible to cover it all in one book.

---

## Colic

This is the term applied when your baby screams, draws up his or her legs and cannot be consoled by holding or further feeding. Doctors are not certain what causes this common problem but I have observed that considerable air is swallowed during the intense crying. This extra air distends the stomach and makes an uncomfortable situation worse which causes more crying. You can see a cycle persisting here. I often suggest methods for reducing the gas and ways to distract the baby until your baby feels better. Pick your baby up when he or she cries, burp your baby, offer a bottle of water, breast feed, give formula or even a pacifier. Carrying your baby around may help. Shoulder pouches or sacs work well so that you can perform household tasks and soothe the baby at the same time. The colicky period may last only days but commonly lasts a few weeks. It always goes away.

---

## Crying babies

This is an excerpt from a flyer on *Shaken Infant Syndrome* I believe has some helpful information to all parents with small children.

No one likes to listen to a baby cry for a long time. It is irritating and frustrating. Babies can cry a lot when they are hungry, wet, tired, or just lonely. They can cry at certain times of the day or night, usually when they want to sleep or eat. Crying is one way babies express their discomfort.

Your baby might be colicky if he or she cries a lot, curls up and then straightens out over and over again.

If you feel, your baby is crying a lot, I should examine your baby to rule out medical causes. You can try the following to calm your infant's crying:

- Feed your baby and burp him or her several times.
- Change your baby.
- Offer your baby a pacifier
- Hold your baby while walking or rocking.
- Take your baby for a ride in the stroller or car.
- Put your baby in a baby swing.
- If you are nursing, avoid gas forming vegetables or caffeinated beverages.

Be patient. Your baby does not hate you or want to ruin your life.

- Put your child in a safe place and leave the room for a few minutes.
- Call a friend or neighbor.
- Ask someone else to take care of your baby for even a short time.
- Take ten deep breaths, and then take 10 more.
- Do something to calm yourself. Play your favorite music. Make a cup of tea or coffee. Exercise or take a shower. Read a magazine or book.
- Change your activity. Shake a rug. Do dishes or laundry. Scrub a floor. Beat a pan or pillow. Throw away unwanted trash.

- Sit down, close your eyes, and think of a pleasant memory. Relax without moving for several moments.
- If all else fails, wrap your baby in a soft blanket. Put your baby on his or her right side or stomach in a dark, quiet room. Leave your baby alone and take a break in another room.

We all experience some occasion when we have hard-to-control anger and frustration. No matter how impatient you feel, don't shake or hit your baby. Your baby will outgrow the constant crying. For now, holding and cuddling tells your baby you love him or her and you want your baby to feel better.

---

## **Jaundice of the newborn**

Jaundice is a common occurrence in newborn babies. Jaundice means a yellowish coloration of the skin that can be harmless

in the newborn, or a sign of disease in the infant, older child, or adult.

In the newborn this yellow skin color commonly appears at about 2 to 4 days after birth. At the time of the baby's delivery the baby's blood system maintains extra red blood cells, because the birth process places extra demands for nutrients. After the need for added oxygen disappears, the body breaks down some red blood cells. The chemical by-products of blood break-down get filtered through the liver. One chemical called bilirubin is released into the blood and this same chemical causes a yellow color when it gets deposited in the skin. For most babies the appearance of the yellowed skin is barely noticeable and many parents do not even detect it. The face is the first area to pick-up the yellowing, and you will see the yellow color spread toward the feet, if the jaundice is worsening. If you notice the whites of the eyes (sclera), becoming yellow, the jaundice is getting worse. By the time the body, legs, or eyes are yellow, the jaundice requires further medical attention. You should call the my office. Make the judgment about the severity of jaundice after you place your child in natural light. Artificial lights used in a lighted room with curtains closed or at night will give the false impression of jaundice. Most artificial lighting will give the skin a yellow coloring.

There might be a need to treat jaundice depending on its cause. I just described the normal or physiologic jaundice of the newborn. But there can be many causes for your baby's skin to yellow. A common cause is a blood incompatibility called "ABO" incompatibility. This is when the baby's major blood groups differ from the mother's. The most common group incompatibility is when the baby's blood type is "A", "B", or "AB" and the mother's blood type is "O". The mother can create antibodies to the baby's blood group. Damage to the baby's blood results in high levels of bilirubin in the blood. Bilirubin is harmless in low levels, but if the levels are very high, injury to the nervous system and brain occur. In most cases this problem is picked up shortly after birth with normal screening of babies who are born from group "O" mothers. When the level of bilirubin reaches a certain level, treatment might be started. The traditional treatment is with phototherapy. This is a special light treatment which lowers the bilirubin in the baby's body. Babies are placed naked under the light with eye patches protecting the eyes from the intense light. This treatment can last from one day to many days depending on the severity of the jaundice and health of the baby.

Another blood incompatibility problem that results in a more serious problem is Rh incompatibility. This is a blood factor we call (+) positive or (-) negative, such as A + or AB -. This type of blood reaction can be serious and require blood exchanges and phototherapy.

Other reasons for jaundice in the newborn period are many. One common problem in breast feeding mothers is persisting jaundice or jaundice without blood group incompatibilities. There appears to be an association with breast feeding and exaggerated jaundice. There are certain chemicals produced in breast milk which seem to enhance normal jaundice. It is not always clear whether it is the breast milk or some mild dehydration from inadequate breast milk causing the exaggerated jaundice. The first treatment is to add extra water after feeding. If the jaundice is substantial, the bilirubin is high, and there are no other signs of problems, I might start the baby on formula for one to two days. After the bilirubin is lower and in the safe range, I will restart the breast feeding again. Mothers should discard the pumped breast milk.

Jaundice can also be a sign of infection, hormone imbalance, and appear in premature infants with an immature liver. *Last reviewed 7/16/07*

---

**False jaundice**

Many parents will bring in their older infant, usually 6 to 18 months of age. These parents are concerned about their child's yellow skin. When examined closely, these kids have especially yellow soles of their feet, palms of their hands, and general yellowness of the rest of their skin. What is missing is yellowness of the whites of the eyes (sclera). Further questions turns up a strong emphasis in the diet of yellow vegetables. This increased pigmentation is harmless and disappears if there is a change in the diet with a decrease in carrots and squash.

## Office Policy and Information

### Office visits

Call the office within a couple of days of arriving home. Make an appointment for the baby for a two-week check up. Please bring an extra bottle of formula, water or a pacifier, and a few extra diapers with you to the appointment.

Most of our policies and resources are available here at [www.markmsimonian.medem.com](http://www.markmsimonian.medem.com). Please check for any updates. Also check [www.msimonianmd.com](http://www.msimonianmd.com) for patient specific information.

---

### Telephone and on-line consultation

Many problems can be solved by simply calling our office. If you have an emergency, please say so! Please try to call during office hours. Always have a pencil and paper ready

when you call and be prepared to give the following information : Child's name, age, symptoms, temperature, and any special problem such as a heart defects, etc. Treatments given before calling (include all prescription and non-prescription medications) and what response you have gotten.

During regular office hours, my receptionist can answer your minor questions, but will always consult with me for prescribing treatment or medication. If your child's problem requires my attention, I will call you back as soon as possible. If you have an emergency, please say so. After office hours, an answering service will answer the phone. Non-emergency will be returned within an hour. Emergency calls have priority and will be returned as soon as possible.

I also provide you with non-emergent consultations (On-line Consultation) through my Web site for minimal cost if a trip to the doctor to ask questions isn't convenient. There are situation when an exam isn't required like follow-ups or behavior issues.

---

### New financial policy

Many of our patients have requested that our financial policy be made available to them to look over before their first office visit. This is a copy of our policies for you to read.

The payment for each visit will be the responsibility of the adult who accompanies the child or adolescent. Unless specific arrangements are made in advance, our office will not bill different parents in cases where the court has assigned financial responsibility to the other adult not present. We are happy to assist you in getting reimbursement from your insurance company. If you are a participating member in a plan in which we belong, our office will do the billing. We ask that you notify your insurance company that payment be directed to our office and not to you.

Most of our patients pay at the time of the visit. If you can not do so, *arrangements should be made in advance*. Our office will accept post-dated checks, but speak with the front office before making checks not dated for the day of the visit. If at any time a check is returned, you will be responsible for a service charge of \$15.00.

**At this time we are accepting charge cards such as Mastercard or Visa.**

Our office is not accepting Medi-Cal accounts or Healthy Families.

---

### Scheduling

We are always happy to see your children if you believe they are ill or if you have questions. To minimize your wait it helps if we know *in advance* if you wish an additional child to be seen. We can fit in additional children but scheduled appointments that follow your child's will be delayed.

I hate to make you wait any extra time but the majority of delays are caused by underestimating the complexity of problems or parents requesting that additional children be seen. Your time is too valuable to spend sitting in the waiting room or staring at my posters. So please let us know in advance if you believe there is a possibility that additional time will be needed.

I want your time here to be well spent.

## **Skin and Rashes**

### **Acne (newborn)**

At 1 to 3 weeks of age the infant may develop an acne-like rash on the face which may extend to the scalp and the chest. Do not attempt to treat this rash. The rash resolves on its own without leaving any scars or blemishes. If there are large pustules or cysts, call my office for an appointment.

---

### **Acne (adolescent)**

Acne is the physical change in the outer layers of the skin caused by several factors. It is usually triggered by the hormonal changes of puberty. Increased skin oils accumulate below plugs in the openings of the hair follicles and oil glands. In the area below the plugs, secretions accumulate and skin bacteria grow. These normal bacteria cause changes in the secretions and make them irritating to the surrounding skin. The result is usually a pimple, and occasionally may develop into a larger pocket of secretions or cyst. Blackheads are formed when the surface secretions collect and the tanning pigment called melanin is deposited causing the dark colored pimples.

Cleanliness and good hygiene are important principles for everyone. While excessive dirt will certainly aggravate acne, scrupulous cleaning will not prevent it. I tell adolescents to wash their skin only to keep it clean and comfortable. Extra washing or very vigorous scrubbing is not only unnecessary but potentially harmful. Greases and creams on the skin may aggravate problems. Over-the-counter acne medicines may be quite helpful for many adolescents. The active ingredient of benzoyl peroxide is important. Look for it. This ingredient dries the pimples and helps kill bacteria on the skin. Diet is not an important factor for most people. Some foods obviously do aggravate their acne and these foods should be avoided or reduced. But concerns regarding greasy foods, ice cream, chocolate etc. are overexaggerated.

Sunlight may have definite effects on acne and mild tanning during summer months usually reduces the severity of most acne.

Most acne may be improved by simple home therapy. When you do not feel your adolescent is happy with the progress they have achieved, I have several approaches I can use to control and reduce the severity of the acne. I refer patients when there is no change or satisfactory improvement after I have used prescription treatments.

---

### **Diaper rashes**

If there is a persistent, mild diaper rash you might try treating it before you need to call me. Expose the rash to air for ½ to 1 hour 4 times a day. Avoid using plastic pants. A good adhesive cream or ointment containing zinc oxide applied to the involved area 4 times a day will protect the skin and aid in healing. If these measures don't help after a few days or the rash becomes painful, call the office.

---

### **Birthmarks**

We all want the best for our kids including a beautiful appearance. From birth, parents scrutinize every inch of their child. This is natural and I expect many questions when parents detect any imperfections. At birth the natural trauma produces all types of marks on the body. Bumps and bruises always disappear shortly after birth. Over the eye lids, forehead and the back of the neck are common spots for one of the most frequent birthmarks, a flat slightly reddened area that can be small or a couple of inches in diameter. These are collections of fine blood vessels and pigment that usually fade as the child grows. These are called nevus flammeus. No treatment is needed. Other areas of pigment deposited commonly around the back, or buttocks is called a Mongolian spot or spots. These are found more often in darker pigmented people. These do not disappear and will grow with the body. No treatment or care is necessary because they really don't stand out and these will be covered by all but the most revealing swim suits. Other common birth marks appear as very pale areas

from pea sized to an inch or more. These will later develop into a group a very red fine blood vessels. They will enlarge and be raised above the skin. They can be found anywhere on the body. They will grow as the body grows and during different times of the child's growth will enlarge then later shrink. Called hemangiomas, the good news is most will disappear or gradually fade away. Some can be large and reside on the face or in areas where wear and tear result in repeated bleeding when injured. For cosmetic or practical reason these might need removal or repair. Lasers are used sometimes by experienced dermatologists or plastic surgeons. Most hemangiomas will not need treatment and will fade. And disappear.

Moles can start appearing in middle to later childhood. I will examine these to detect any irregularities. If I am concerned or I feel you request more information or evaluation of these moles, I will discuss a dermatology consult with you. Biopsies of some moles are necessary, but rarely needed. The most common referral to a dermatologist occurs when a mole is bleeding and repeated scratched, along the bra line, neck hand or feet. Some moles are especially large and carry an increased risk of cancer potential. I will measure and discuss referral as necessary. These too are quite rare.

Skin tags can be irritating and can bleed when repeatedly traumatized. In some cases I can tie a knot at their base with a suture and remove them successfully.

---

### **Insect bites**

Summer months invite us out of doors for fun and recreation. Many times recreational activities include unwanted pests like mosquitoes, ants, ticks, fleas, bees and bugs of all sorts.

*What should you expect when these critters bite you?*

Insects bites can cause several different types of reactions. The most common is a localized reaction. Near the bite there will be a raised red bump the size of a small speck to a large welt. Pain may last for a few seconds or minutes.

Often you will notice itching. There may be a small clear blister at the top of the bite. Usually, one bite is present but many can be scattered over the body or several clustered in a group. Examine the entire body thoroughly before calling for advice because certain insects attack specific parts of the body. By knowing where the bite occurred, I can more accurately respond to your questions. Occasionally, the reaction to the bite can be intense, with swelling, redness and warmth extend inches beyond the bite.

---

### **Insect bite treatment**

Most bites are relatively harmless and if you do nothing, your child will do well. If the area around the bite is not clean, clean it.

Scratching an area that is dirty can promote an infection since scratching can break the skin.

To relieve itching, try over-the-counter ½% hydrocortisone creams. Apply the cream four times a day.

Oral antihistamines help too. Children 20 to 30 pounds should take ½ to 1 tsp. Every four hours as needed for itching. Older children 6 to 12 years should double that dose. If sleepiness interferes with their comfort, reduce the dose. A salve of water and meat tenderizer (like Adolph's) can help if applied immediately after the bite or sting. I would not use the salve on a cut or scrape. Wash off immediately if burning occurs.

Stronger medications may be needed but may be prescribed after I have seen the insect bite. Infections can appear after a bite is scratched. Persisting irritation, redness, warmth or streaking red lines could be a localized infection. If these features of the bite are noticed, call my office.

Allergic reactions to an insect bite can be serious, even life threatening. These reactions appear almost immediately after the bite. Swelling and itching are followed by a rash that appears over much of the body.

---

### **Hives**

Hives is an uncomfortable condition produced by a rash made of itchy welts. Oral antihistamines like Benadryl™ are useful in interrupting the allergic reaction — providing relief from the rash and itching. More

serious reactions can include swelling of the fingers, toes, lips or other parts of the body. The airway may swell and difficulty of breathing can follow. This is an emergency! Medical attention must be sought immediately. If your child has ever had a serious reaction from an insect that resulted in difficulty in breathing, please inform our office. I will be better able to advise you and respond when someone calls about your child's allergic reaction. I may prescribe an emergency treatment kit that can be used immediately following a bite. This can be life saving!

Red, itchy, small to large reactions occurring in the skin are often of an allergic nature. Hives appear suddenly anywhere on the body. They may appear as flat, raised or ringed spots up to several inches in size. Reactions to drugs, foods or illness may cause the appearance of hives. They can last minutes or persist for weeks. I notice them more in children a strong history of allergies — asthma, hayfever or eczema. The rash of hives may occur alone or with other allergic symptoms like wheezing or general shock. Unfortunately, most cases don't have a definitive cause.

Treatment should begin by making your child comfortable. You may apply topical creams like Calamine™, Benadryl™ or hydrocortisone. These work well as long as the rash is in a small area of the body, but with hives, the rash is wide spread. It is not practical to cover large areas of the body with creams is not practical. Over-the-counter oral antihistamines work very well to interfere with the release of histamine, the chemical causing the hives. Benadryl™ liquid or capsules provide relief for most children and adolescents. I may prescribe other medications if over-the-counter drugs don't work. Hives persisting longer than a few days require my attention. *Last reviewed 7/16/07*

---

## Facial rashes

One of the most common facial rashes is called impetigo. Impetigo is caused by bacteria such as Streptococcus or Staphylococcus. Children with runny noses from colds or allergies seem to be commonly effected.

Honey colored, crusts build up at the opening of the nose or nostrils. Then there is rapid spread around the mouth and face. Left unchecked, the rash spreads to other areas of the body by scratching. The infection can start as a simple pimple or pustule, enlarging with weeping crusts noticeable in some children. A scratching child collects the bacteria under their nails. If their skin or other children's skin is scratched, new sores develop.

This infection is common before puberty. The chemical structure of the skin is different before puberty and is more susceptible to the invasion of the bacteria often found on normal skin.

At the first sign of this infection some simple measures may prevent spread, control the growth or clear up the topical infection. Many over the counter creams and ointments help. Try Bacitracin™, Neosporin™, or Betadine™. Clearing the crusts with warm compresses, prevents the bacteria growing in the crusts from reinfecting the skin. If a couple of days of treatment produces little improvement, you should set up an appointment to determine if oral antibiotics are needed.

---

## Eczema or atopic dermatitis

Eczema is a very common disease. I will detect some form of this disorder in about 10% of all the children and adolescents I examine. Although the cause is not know, there is a definite family trait producing this red, itchy rash. About ½ of all children diagnosed to have eczema will also have hay fever or asthma.

The first signs of eczema appear after the baby is a couple of months old. Most children will develop the rash by 6 years of age, if they have any tendency to produce it. Characteristically, the rash comes and goes over weeks to months. Most of the damage provoked by this itchy rash is caused from scratching and rubbing it. In babies the rash first appears on the face elbows and knees and diaper area. Later the rash will persist or reappear in the folds of the knees or elbows. Three-quarters of all persons with atopic dermatitis will have the rashes on their hands. The appearance of the rash is not a helpful indicator if your child has atopic dermatitis because its characteristics vary so much individual to individual. Scratch

marks often appear along with scaly, dry skin. Infection is a common complication. The skin can become quite thickened over time because of the frequent rubbing and scratching.

There is a strong family history of asthma, hayfever and atopic dermatitis.

The cause of atopic dermatitis is unknown. The skin becomes inflamed causing redness, itching and swelling. Some trigger or defect in certain skin cells causes them to react and produce the inflammation. Until doctors understand what factors produce the inflammation, the treatment deals with the special trigger to the dermatitis or agents to calm down the inflammation.

Common triggers to produce the persistent inflammation are dry skin, irritants, emotional stress allergens, heat and sweating and infections.

---

### **Dry skin**

Skin primary purpose is to provide a barrier against dirt, infections and chemicals.

In order for skin to provide optimal protection it should be soft and resilient. Atopic dermatitis patients have dry and brittle skin. This appears to be a defect in the normal characteristics of atopic skin. Heat and dryness in the air are hard on normal skin but worse for atopic skin. Too much bathing, soaping and washing with hot water can aggravate atopic dermatitis. They remove the natural moisturizers from the skin.

Stress is a definite factor in developing your child's eczema. Anything that produces stress in your child can trigger an episode, but the problem is determining what things or how much stress is needed to produce the rash. When stress factors are recognized the task is to reduce the stress whenever possible. I didn't say it would be easy.

---

### **Atopic dermatitis treatment**

Ointments are helpful if they are not too thick and are uncomfortable. Creams can be used too. Bath oils work sometimes and all of these work best when applied after bathing.

Corticosteroids are very helpful and are used by applying them to the skin. These are not the same steroids athletes use. Prescription steroids are more powerful and effective than the over the counter weaker versions of the same medications. These will calm the effects of the itching and redness.

Antihistamines are used to reduce the intense itching apparent in many children. The side effects can cause sleepiness or irritability and their use is on a case by case basis.

Antibiotics are used when the severe scratching can contribute to infections of the irritated, inflamed skin. Over the counter use of neosporin, bacitracin or Betadine might work well, but in some cases I will need to determine the degree of infection and the need for oral antibiotics.

Atopic dermatitis might disappear in older childhood or adolescence. It can persist through adulthood, especially if the family history of adult eczema is present.

Atopic dermatitis should not be disabling or disfiguring if adequate efforts are made to treat it.

---

### **Cradle cap or seborrheic dermatitis**

Cradle cap is a very common condition of infancy, although a variation of the condition occurs well into adulthood.

You will notice an oily, yellow or white scaling

over the top of the head. There may be scaling and redness in the eyebrows, eyelashes, creases of the nose, behind the ears, around the umbilical cord and various other places. It can become quite thick or be barely noticeable. The infant is not bothered by its presence. It may disappear without treatment or persist indefinitely.

Treatment begins by loosening the scales with mineral oil and gentle brushing with a soft toothbrush. Wash with Dove™ or a mild soap. Regular treatment may be all that is necessary. In older children, anti-dandruff shampoos like Sebulex™, Selsun™, or Head and Shoulders™ will help. In severe cases, hydrocortisone lotions may be needed.

## Advil and Motrin Table

As effective as Tylenol™-like medications for fever, pain, or inflammation reduction					
		10 mg/kg		15 mg/kg	
		Fever <102F°		Fever >102F	
			°		
Age	Weight (lb)	(mg)		(mg)	
6-11 mos	13-17	50		75	
12-23 mos	18-23	100		150	
2-3 yrs	24-35	150		225	
4-5 yrs	36-47	200		400	
6-8 yrs	48-59	250		375	
9-10 yrs	60-71	300		450	
11-12 yrs	72-95	400		800	
Fever reduction in adolescents or adults					
400-600 mg every 4 to 6 hours as necessary					

## Tylenol Table

### Drops

#### *Improved dosage chart*

Age	0-3 mos	4-11 mos	12-23 mos	2-3 yrs	4-5 yrs	6-8 yrs	9-12 yrs
Weight(lbs)	6-11	12-17	18-23	24-35	36-47	48-59	60-70
Dose of Tylenol (mg)	40	80	120	160	240	320	400
Droppersfull	1/2	1	1 1/2	2	3	4	5

### Elixir

#### *Improved dosage chart*

<b>Age</b>	4-11 mos	12-23 mos	2-3 yrs	4-5 yrs	6-8 yrs	9-10 yrs	11-12 yrs
<b>Weight (lbs)</b>	12-17	18-23	24-35	36-47	48-59	60-71	72-95
<b>Dose (mg)</b>	80	120	160	240	320	400	480
<b>Teaspoons</b>	1/2	3/4	1	1 1/2	2	2 1/2	3

### Chewable Tablets

#### *Improved dosage chart*

Age (yrs)	1-2	2-3	4-5	6-8	9-10	11-12
Weight (yrs)	18-23	24-35	36-47	48-59	60-71	72-95
Dose (mg)	120	160	240	320	400	480
Tablets	1 1/2	2	3	4	5	6

*Usual dosage: Dose may be repeated 4 to 5 times daily. Do not exceed 5 doses in 24 hours.*

**You can give Tylenol™ without hesitation with any illness or medication!!!**

## Index

## A

ABO incompatibility .....	83
acne, adolescent .....	87
acne, baby .....	87
acute epiglottitis .....	39
adding solid foods .....	20
adenoids .....	46
Advil Table .....	92
Advil™ .....	68
Afrin™ .....	12
alarm devices .....	15
allergic conjunctivitis .....	12
allergic rhinitis .....	12
amblyopia .....	24
animal or human bites .....	58
ANSI .....	59
antibiotic medication .....	67
appointment, first for baby .....	85
arrhythmia .....	74
aspirin .....	68
asthma .....	65
asthma attack .....	65
astigmatism .....	26
atopic dermatitis .....	90
atopic dermatitis, treatment .....	90
attention deficit disorder .....	14

## B

babies first month .....	32
baby measles .....	48
baby sitter reminders .....	75
Babylax™ .....	64
Bacitracin™ .....	89
bacterial infections .....	47
barking cough .....	46
bed time problems .....	18
<b>bedwetting</b> .....	15, 47
Benadryl™ .....	46, 89
benzoyl peroxide .....	87
Betadine™ .....	89
bicycle helmet .....	59
bilirubin .....	83
birthmarks .....	87
bites .....	58
biting .....	16
blackheads .....	87
bladder control .....	15
bladder infections .....	47
blepharitis .....	25
blocked tear duct .....	27
books, child care .....	82
bottle nipples .....	19

botulism .....	46
bowlegged .....	77
brain tumors .....	80
BRAT .....	63
BRAT diet .....	48
breast feeding .....	19
bronchiolitis .....	66
bruises .....	58
bulging eyes .....	35
burns and scalds .....	57
burns with blisters .....	57

## C

Calamine™ .....	46
canker sores .....	27
cataracts .....	24
cellulitis .....	52
chalazion .....	27
chemical burns .....	57
chicken pox .....	46
Chicken Pox .....	54
choking .....	56
chronic fatigue .....	48
cleaning bottles .....	19
Coccidiomycosis .....	52
cold .....	45
colic .....	82
conjunctivitis .....	46
constipation .....	64
constipation, newborn .....	63
convulsions .....	57
corneal abrasions .....	25
cow's milk .....	21
cradle cap .....	90
crops .....	46
crying babies .....	82
curved spine .....	79
cuts .....	58, 62

## D

DDAVP .....	15
decongestants .....	12
DEET .....	51
Desitin™ .....	67
diaper rash .....	87
diarrhea .....	63
diphtheria .....	37
drooping eyelids .....	25
droopy eyelids .....	24
dry skin .....	90
dysmenorrhea (primary) .....	28
dysmenorrhea (secondary) .....	28

**E**

ear pain	23
earaches	23
Ebstein-Barr virus	36, 49
eczema	89, 90
EKG	74
electrical burns	57
electrocardiogram	74
epistaxis	26
eye crossing	23, 81
eye massage	24
eye problems	23

**F**

facial rashes	89
fainting	57
false jaundice	84
family resources	70
farsightedness	25
feeding	19
feeding enough	20
female adolescents	28
femoral torsion	78
fever	45
Feverol™	45
Fifth Disease	54
financial policies	85
finger nail injury	62
fingers smashed	61
flatfeet	77
flu	68
foreskin	29
formula	19
fractures	57
fructose	17
fumes, gases, or smoke	58

**G**

gastroenteritis	48
gastroesophageal reflux	17
Gatorade	63
GERD	17
German Measles	42
glaucoma	24
glycerin suppository	64
growing pains	78

**H**

hand, foot, and mouth disease	47
hay fever	12
head injuries	56, 57
head lice	46
headache	80
helmet	61

helmet protection	59
hemangiomas	88
hemophilus meningitis	39
hepatitis	50
Hepatitis B	43
hernia	77
hiccup, babies	81
histamine	12
hives	88
honey	46
humidifier	46
hyperactive child	14
hyperopia	25

**I**

ibuprofen	68
immune globulin	36, 50
immunization schedule	43
impetigo	49, 52, 89
impulsive	14
Incubation Chart	54
influenza	49
inguinal hernia	77
insect bite treatment	88
insects bites	88
irregular heart beat	74

**J**

jaundice	50
jaundice, newborn	83
jumpers knee	79

**K**

Karo™	64
knee pain	78
knocked-kneed	77

**L**

lacerations	62
lactose	16
large or deep burns	57
lockjaw	39
loss of consciousness	56
Lotramin™	48
Lyme disease	50

**M**

Measles	42
medication dosing	67
menarche	28
menses	28
Micatin™	48

migraine headache .....	80
minerals .....	22
MMR vaccine .....	41
moles .....	88
mononucleosis .....	50
mother's breast care .....	20
motor activity (1 month) .....	32
Motrin Table .....	92
mumps .....	42
myopia .....	25

**N**

National Vaccine Injury Compensation Program .....	42
navel .....	81
nearsightedness .....	25
Neosporin™ .....	89
Neosynephrine™ .....	12
nevus flammeus .....	87
Nintendo disease .....	74
nits .....	46
Nix Cream Rinse .....	46
nosebleeds .....	58
nursing frequency .....	20
nursing position .....	20

**O**

On-line Consultation .....	85
Orabase™ .....	27
oral contraceptives .....	29
orange juice .....	21
OTC .....	67
otitis externa .....	26
otitis media .....	26
over-the-counter medicines .....	67

**P**

pain management .....	69
paralysis .....	40
Pedialyte .....	63
penis .....	29
pertussis .....	38
phototherapy .....	83
pigeon toes .....	77
pink eye .....	25, 46
pinworms .....	52, 64
PMS .....	35
Poison Control Center .....	75
poisons .....	58, 75
polio .....	39
potty chair .....	31
premenstrual symptoms .....	30
premenstrual syndrome .....	35
ptosis .....	24, 25
puberty (female) .....	28
puncture wounds .....	58
pus in eye .....	23

Pyrethrins .....	51
------------------	----

**Q**

Q-tip™ .....	23, 46
--------------	--------

**R**

R.I.C.E. ....	61
rectal bleeding .....	64
rectal pain or itching .....	64
resources .....	82
respiratory flu .....	49
Respiratory Syncytial virus (RSV) .....	66
Reye's syndrome .....	50
Reye's Syndrome .....	68
Rh incompatibility .....	83
ring worm .....	48
Ritalin .....	14
roller blades .....	61
roller skates .....	61
roseola .....	48
Rubella .....	42
Rubeola .....	42

**S**

Sabin .....	40
Salk vaccine .....	40
San Joaquin Valley Fever .....	52
scheduling appointments .....	85
school phobic child .....	17
scoliosis .....	79
scrape .....	58
scratched cornea .....	25
scratches .....	62
seborrheic dermatitis .....	90
secondhand smoke .....	65, 66
seizure .....	80
seizures .....	57
Selsun™ .....	91
<i>Shaken Infant Syndrome</i> .....	82
SIDS, smoking .....	66
skate board .....	61
skin exposure .....	58
skin tags .....	88
skin wounds .....	58
sleeping babies .....	81
sleeping position .....	69
snake bites .....	59
sneeze, babies .....	81
SNELL .....	59
sorbitol .....	17
spanking .....	13
splinter .....	58
spoiled children .....	13
sponge baths .....	81
sprain .....	61
sprains .....	57

stings.....	58
stomach flu .....	48
stomach pains .....	16
stools, babies.....	81
strabismus .....	24
stuttering .....	32
styes.....	27
Sudden Infant Death Syndrome.....	69
swimmer’s ear .....	26
swimming pool injuries .....	60
swollen eyelids .....	25
swollen neck glands.....	42
Symmetrel™.....	50
syrup of ipecac.....	76

**T**

tantrums .....	13
tear duct .....	24
teeth injuries, primary.....	59
teeth injuries, permanent.....	59
teething and fever .....	74
telephone manners .....	85
temper tantrums .....	14
terrible twos.....	13
tetanus.....	39
three month old.....	33
thyroid .....	35
tibial torsion.....	78
tick .....	58
time outs .....	13
Tinactin™.....	48
toes smashed.....	61
toilet training .....	31
tonsils.....	46
toy.....	57
training panties .....	31

Tuberculosis .....	51
two month old .....	33
Tylenol™ .....	45, 68, 69

**U**

umbilical cord .....	81
umbilical hernia.....	77
uncircumcised penis .....	29
urinary tract infections .....	47

**V**

vaginal bleeding (newborn).....	29
vaginal discharges .....	30
vaporizer .....	46
vascular headaches.....	80
Vaseline™.....	67
viral infections.....	47
Visine™ .....	12
vision screening.....	24
vitamins .....	21

**W**

water.....	21
wet the bed .....	15
whooping cough.....	39

**Y**

yawn, babies.....	81
yellow skin .....	84