Ready for school: backpacks, packing lunches, when to keep your kid home for illness, and more

Now that you just read how to drop your kid off at school on the first day, you may be backpack shopping, pondering what to send your child for lunch, and knowing that your child will have difficulty waking up early for school. Never fear! Your Two Peds can help you and your kids get ready for school.

First, make sure your child’s backpack fits correctly and is not too heavy. Our guest blogger, a pediatric physical therapist, provides tips to help lighten the load.

Help your child get back on a school-friendly sleep schedule. If your child is still in summer vacation sleep mode, we provide ways to help get your child's sleep back on track.

If your child brings lunch to school, you may need some hints on what to pack and how to beware of junk food disguised as healthy food. And this post provides suggestions for healthy snacks.

Need suggestions on how to motivate your child to want to learn? Two former school principals share their wisdom in this post.

Finally, you should know when to keep your child home for illness. This post also contains some surprising truths about when you can send your child back to school during as well as after certain maladies.

Julie Kardos, MD and Naline Lai, MD
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How to stop nail biting-thoughts to chew on

A preschooler nibbles on her nails.

Stop nail biting! One of our readers wrote to us: “My 3.5-year-old daughter has started biting her nails to the quick. She does have a new little sister so perhaps it is stress/anxiety about that, but I don’t know what to do. Do I ignore it? Offer rewards for not biting? Please help – the habit drives me nuts and her poor little fingers are looking worse for the wear (and painful).”

As many of you have likely already discovered, telling your kid, or pleading with them, or bribing, ignoring, or yelling at them, will not help your kids stop nail biting.

Nail biting is a common childhood habit. Really common. In fact, according to this review article from 2015, it is THE most common habit seen in school-aged and college-aged kids. As many as 60% of kids, at some point, bite their nails. Nail biting usually starts between the ages of three to six years, so our reader's child is right on target for this habit.

I am amused that many of the parents who ask me how to help their kids stop biting their nails are, themselves, nail biters. I will point out that even if we can't stop nail biting, the concerned parent is a living example of a nail biter who still grows into a successful adult.

Assuming that your child is otherwise acting well, eating and sleeping normally, and mostly cheerful, it is not always important to identify the trigger of nail biting. More importantly, make sure your child washes their hands after playing outside and before eating (and nail biting) to limit germ spread. Check their fingers for signs of infections that can result from nail biting.

What to do

A quick internet search reveals dozens of products that you can dab onto your child's fingers to discourage nail biting. Products with nasty tasting ingredients such as "bitter apple" tote promises such as "stop nail biting instantly." Unfortunately, most nail biters are not deterred by paint-on products.

Usually kids have a hard time breaking a habit unless they REALLY want to break it themselves. Here are some suggestions to help:

- Offer painting nails or small rewards for not biting nails.
- Don't be a nag.
- Establish a code word for *stop biting your nails* that only your child knows. The word can be a nonsense word

(e.g. oogleschmertz) or a word entirely out of context (e.g. elephant). For younger kids especially, this creates an environment of humor, rather than annoyance when you are reminding them to stop biting.

- Substitute a less annoying habit for nail biting. Hand them something to keep their hands busy. Give them a squishy toy to squish or a hair scrunchy to wear on their wrist to flick.
- Offer older kids sugarless chewing gum to keep their teeth busy.

If all else fails, take heart in one study that came out in favor of nail biting (and thumb sucking). Perhaps it's not imperative to stop nail biting after all. The study showed that nail biters and thumb suckers had a lower rate of atopic sensitization (medical term for allergic eczema) than their non-nail biting or thumb sucking peers. The researchers conclude "Although we do not suggest that children should be encouraged to take up these oral habits, the findings suggest that thumb sucking and nail biting reduce the risk for developing sensitization to common aeroallergens." In other words, the nail biters show fewer allergy symptoms in their skin than the non-nail biters.

Let's face it: We all are creatures of habit. The key is to make sure the habit is not self-detrimental. Every childhood habit does not need to be broken immediately, even if it drives us parents crazy.

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Easy way to remove a tick

ick, a tick

I was grumpy all morning after realizing that my dog was out of tick repellent. Really grumpy. I did not like the thought of having to remove a tick from my dog.

After all, on the East Coast of the United States, we are seeing ticks galore. All month long, parents who have had to remove a tick have been bringing us presents such as the one pictured here. Yes, that is a tick you see nicely trapped in tape. Sometimes when parents bring us a tick, it’s still clinging to the child and they ask us to remove it. To save you a trip to the doctor’s office, here is a quick refresher on how to pluck the bugs off:

How to remove a tick:

1. Take a deep breath and **pretend that it's just a speck of lint**—not an ugly critter with a bloated stomach and writhing legs.
2. **Use tweezers** and firmly clasp the head. If the tick is tiny, you will end up grabbing the entire body.
3. **Pull the tick straight up and off**. Hint: Press down on the skin on either side of the tick so that the skin doesn't pull up when you pull the tick off. This lessens any pinching sensation your child may feel.

How NOT to remove a tick:

Please do not try to burn a tick off—you'll just burn your child's skin.
Avoid suffocation techniques such as covering a tick with petroleum jelly (Vaseline) or nail polish. These techniques are not very effective, they allow the tick to stay on for a longer period of time, and also they may cause the tick to become slippery and difficult to grasp.

What to do after you have removed the tick:

After removal, if the tick's head is left behind, don't go digging for it. Just like a tiny splinter, your skin will naturally try to expel it. Soaking the area in warm water will help the process along. Don't worry about disease transmission: there is not any disease stuck in a tick's head.

Wash the skin where the tick was using soap and water as you would any cut to prevent a skin infection. A small, minimally tender, pimple-like bump is a common reaction which may linger for a few days. This bump is an irritation response of the skin. If the tick was a deer tick (typically the size of a

poppy or sesame seed), watch for the rash of Lyme disease that appears as a flat, pink, round patch about a week later. The patch may clear in the center and grows to at least 2 1/2 inches across.

My daughter told me that once, a girl at her lunch table had a tick on her. None of the kids could pick it off and the girl sat screaming until the lunch lady came over to help her. Maybe you'll be the lucky adult called over to help next time.

Just remember…pretend it's a speck of lint.

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Poison ivy: stop the itch

Teach your child to recognize poison ivy: "leaves of three, let'em be!"

Recently we've had a parade of itchy children troop through our office. The culprit: poison ivy.

Myth buster: Fortunately, the rash of poison ivy is NOT contagious. You can "catch" a poison ivy rash ONLY from the plant, not from another person.

Another myth buster: You can **not** spread the rash of poison ivy on yourself through scratching. However, where the poison (oil) has touched your skin, your skin can show a delayed reaction- sometimes up to two weeks later. Different areas of skin can react at different times, thus giving the illusion of a spreading rash.

Some home remedies for the itch:

Hopping into the shower and rinsing off within fifteen minutes of exposure can curtail the reaction. Warning, a bath immediately after exposure may cause the oils to simply swirl around the bathtub and touch new places on your child.

Hydrocortisone 1%- This is a mild topical steroid which decreases inflammation. We suggest the ointment- more staying power and unlike the cream will not sting on open areas, use up to four times a day

Calamine lotion – a.k.a. the pink stuff- This is an active ingredient in many of the combination creams. Apply as many times as you like.

Diphenhydramine (brand name Benadryl)- take orally up to every six hours. If this makes your child too sleepy, once a day Cetirizine (brand name Zyrtec) also has very good anti-itch properties. Some doctors recommend giving it twice a day- ask your pediatrician.

Oatmeal baths – Crush oatmeal, place in old hosiery, tie it off and float in the bathtub- this will prevent oat meal from clogging up your bath tub. Alternatively buy the commercial ones (e.g. Aveeno)

Do not use alcohol or bleach– these items will irritate the

rash more than help

The biggest worry with poison ivy rashes is the chance of infection. Just like with an itchy insect bite, with each scratch, your child is possibly introducing infection into an open wound. At night, turn up the air conditioning and put your child into pajamas that cover up the poison ivy. Kids who don't scratch in the day often scratch subconsciously at night. Unfortunately, it is sometimes difficult to tell the difference between an allergic reaction to poison ivy and an infection. Both are red, both can be warm, both can be swollen.

However, infections cause pain – if there is pain associated with a poison ivy rash, think infection. Allergic reactions cause itchiness- if there is itchiness associated with a rash, think allergic reaction. Because it usually takes time for an infection to "settle in," an infection will not occur immediately after an exposure to poison ivy. Infection usually occurs on the 2nd or 3rd day of scratching. If you have any concerns take your child to her doctor.

Generally, any poison ivy rash which is in the area of the eye or genitals (difficult to apply topical remedies), appears infected, or is just plain making your child miserable needs medical attention.

When all else fails, comfort yourself with this statistic: up to 85% of people are allergic to poison ivy. If misery loves company, your child certainly has company.

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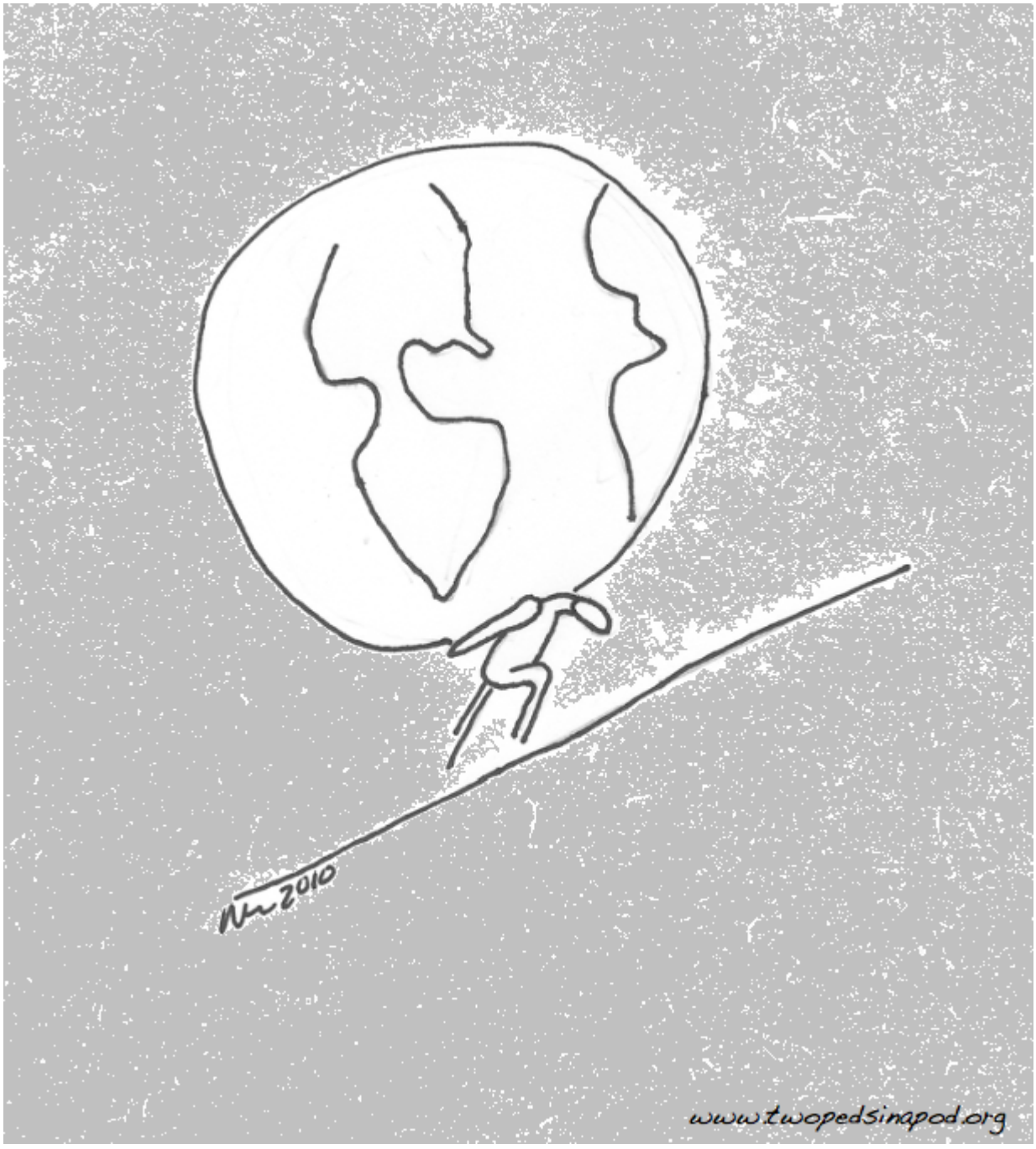
Discussing suicide: how much should I tell my kids?



In the wake of chef Anthony Bourdain and designer Kate Spade's deaths from suicide, you may be wondering how to address the topic of suicide with your child. We bring back psychotherapist Dina Ricciardo's post for guidance:

"Hi, it's me, Hannah. Hannah Baker." So begins the first

episode of *13 Reasons Why,* a thirteen installment Netflix series that focuses on the aftermath of the suicide of a 17-year-old high school student. Based on the novel by Jay Asher, the series has sparked quite a bit of debate and concern among parents and mental health professionals. At its best, the series has served as a conversation starter; at its worst, it has glamorized suicide and the fantasy of revenge. At the end of the day, however, an important question remains: How do we talk with our kids about suicide? While many difficult topics have become increasingly safer to discuss, suicide is one that is still shrouded in secrecy and shame. In fact, it is so difficult to talk about that I had a hard time writing this post. Finding the right words about something that often remains unspoken is not an easy task. So if circumstances require it, how are we to explain suicide to our children?

According to the American Foundation for Suicide Prevention, research has shown that over 90% of people who died by suicide had a diagnosable, though not always identified, brain illness at the time of their death. Most often this illness was depression, bipolar disorder, or schizophrenia, and was complicated by substance use and abuse. Just as people die from physical illnesses, they can die as the result of emotional ones. If we can change the narrative about suicide from talking about it as a weakness or character flaw to the unfortunate outcome of a serious, diagnosable, and treatable illness, then it will become easier for us to speak with honesty and compassion.

Telling the truth about any death is important. While it is natural for us adults to want to protect our children from pain, shielding them from the truth or outright lying will undermine their trust and can create a culture of secrecy and shame that can transcend generations. We can protect our children best by offering comfort, reassurance, and simple, honest answers to their questions. It is important to

recognize that we adults typically offer more information than our children require. We should start by offering basic information, then let them take the lead on how much they actually want to know.

For young children, your statements may look something like this: “You have seen me crying, that is because I am sad because Uncle Joe has died.” They may not even ask how the death occurred, but if they do, you can say “He died by suicide. That means he killed himself.” The rest of the conversation will depend on the child’s response. With older children, the narrative can follow a similar theme yet use more sophisticated language. The older the child, the more likely they are to ask direct questions. Some examples of honest answers are “Do you know how people have illness in their bodies, like when Grandma had a heart attack and our neighbor had cancer? People can get illness in their brains too, and when that happens, they feel confused, hopeless, and make bad decisions. Uncle Joe didn’t know how to get himself help to stop the pain.” If they ask how the suicide occurred, you can say “With a gun” or “She cut herself.” Sometimes you will have to say “I don’t know. I wish I knew the answer.” Whatever the age of your child, do your best to use simple, truthful language.

Regardless of age, children converse about and process death differently than adults. If you tell your child about a suicide, it is likely that he/she will want to talk about multiple times over the course of days, weeks, or even years. Keep the dialogue open, and check in with them periodically if they have questions. If you find that you or your family is in need of the support of a professional, you might want to consider a bereavement group or a trained professional who specializes in grief. These resources are available through online directories, local hospitals, and the Psychology Today therapist finder. Overall, be aware that providing truthful information, encouraging questions, and offering loving

reassurance to your children can allow your family to find the strength to cope with terrible loss.

(Excerpts taken from The American Foundation for Suicide Prevention's "Talking to Children about Suicide", www.afsp.org.)

Links:

Sesame Sreet Workshop's When Families Grieve
The Dougy Center for Grieving Children and Families
The American Foundation for Suicide Prevention
Hands Holding Hearts (Bucks County, PA)
The Jed Foundation

Dina Ricciardi, LSW, ACSW

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Guest blogger Dina Ricciardi is a psychotherapist in private practice treating children, adolescents, and adults in Doylestown, PA. She specializes in disordered eating and pediatric and adult anxiety, and is also trained in Sandtray Therapy. Ricciardi is a Licensed Social Worker and a member of the Academy of Certified Social Workers. She can be reached at dina@nourishcounseling.com.

Stealthy Salmonella! Not just in your eggs

Raw chicken left out overnight—Dr. Lai's recipe for Salmonella

These days it seems that the bacteria *Salmonella* is lurking everywhere. Last month's egg recall for possible *Salmonella* contamination affected over 200 million eggs, but *Salmonella* is not just in eggs. In the last few months, dried coconuts and even guinea pigs (as pets, not as food!) have caused people gastroentestinal misery.

Nontyphoidal *Salmonella* usually causes fever and crampy diarrhea. Sometimes the stools contain blood. This stomach bug mainly lurks in raw poultry, raw eggs, raw beef, and unpasturized dairy products. Luckily, *Salmonella* does not jump up and attack humans. In general, people are safe from disease as long as they do not eat salmonella-infested food. But children below the age of five often put their hands in their mouths and can acquire *Salmonella* after touching a contaminated source.

Reptiles such as lizards and turtles can carry *Salmonella* in their stool and are not recommended as pets for young children. Turtles that are four inches or smaller (about the

size of a deck of playing cards) are most likely to harbor the bacteria. As a preschooler, Dr. Kardos remembers that her tiny pet turtle suddenly disappeared. Her parents told her that "Her pet would be happier if it went outside to the stream to swim with the other turtles." In retrospect, Dr. Kardos thinks her pediatrician dad was worried about *Salmonella* and made the turtle magically disappear.

Even cute little chicks can be problematic. *Salmonella* carried in the gut of a chick can contaminate the entire surface of a chick. So, although kissing and cuddling a chick makes for a good Instagram post, discourage your children from doing so.

Unfortunately, you cannot depend on a warning stench arising from your lunch to warn you that it is inedible. *Salmonella* often hides in food and it is difficult to tell what is or is not contaminated. So how can you prevent your kids from catching *Salmonella*?

Luckily *Salmonella* is killed by heat and bleach. Even if an otherwise fine-looking and odorless raw egg has *Salmonella*, adequate cooking will destroy the bacteria. Gone are the days when parents can feed kids soft boiled eggs in a silver cup, have kids wipe up with toast the yolk from a sunny-side up egg, add a raw egg to a milkshake, or let their kids lick the left-over cake batter from the mixing bowl. Instead, cook hardboiled eggs until the yolks are green and crumble, and make sure your scrambled eggs aren't runny. Wash all utensils well. The disinfecting solution used in childcare centers of ¼ cup bleach to 1 gallon water works well to sanitize counters. Do not keep perishable food, even if it is cooked, out at room temperature for more than two hours. And wash, wash, wash your hands.

A mom once called us frantic because her child had just happily eaten a half-cooked chicken nugget. What if this happens to your child? Don't panic. Watch for symptoms – the onset of diarrhea from *Salmonella* is usually between 12 to 36

hours after exposure but can occur up to three days later. The diarrhea can last up to 5-7 days. If symptoms occur, the general recommendation is to ride it out. Prevent dehydration by giving plenty of fluids. My simple rule to prevent dehydration is that more must go in than comes out.

Although of unproven benefit, antibiotic treatment may be considered if your child is at risk for overwhelming infection, including infants younger than three months old and those with abnormal immune systems (cancer, HIV, Sickle Cell disease, kids taking daily steroids for other illnesses) or those with chronic gastrointestinal tract diseases*. Using antibiotics to treat a typical case of salmonella not only promotes general antibiotic resistance, but also does not shorten the time frame for the illness. In fact, the medication can prolong how long your child carries the germ in his stool.

Pictured above is a pot of chicken Dr. Lai accidentally left out overnight one warm summer night. Yuck.

Naline Lai, MD and Julie Kardos, MD

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**Red Book*, 2015 Report of the Committee on Infectious Diseases, American Academy of Pediatrics

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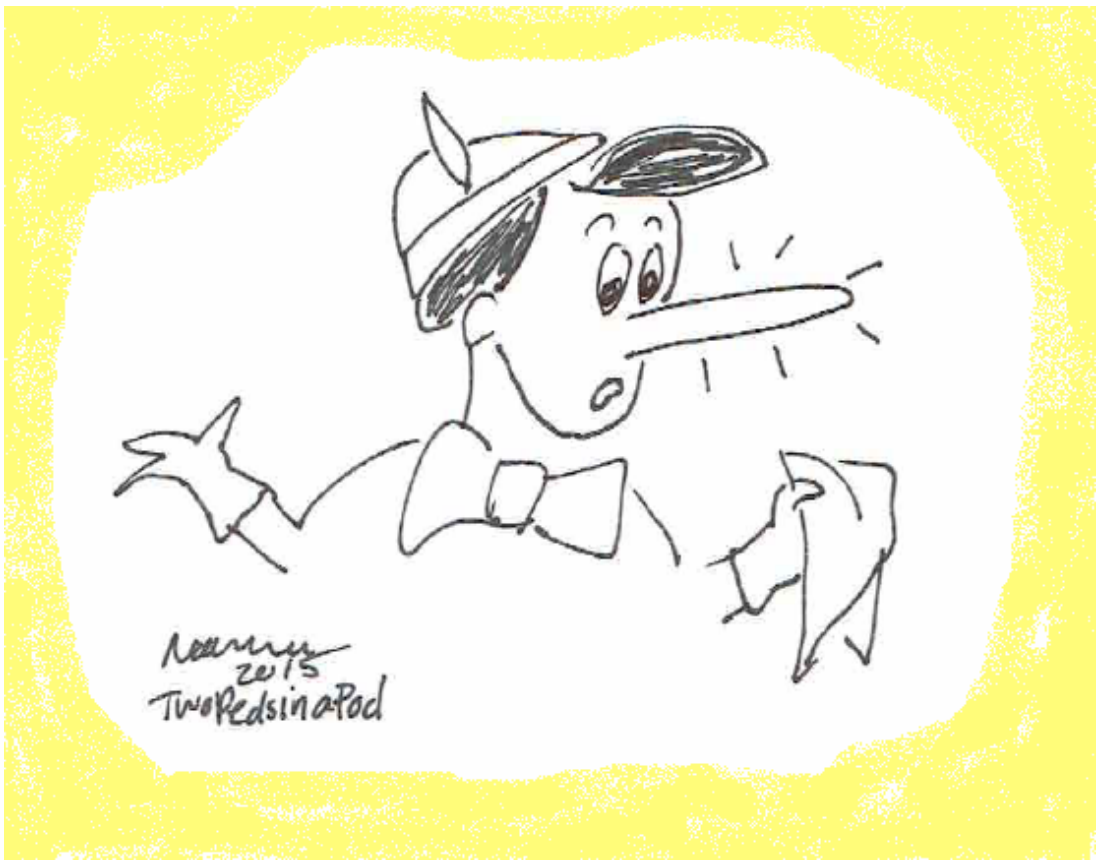
How to treat your kid's allergies: sorting out over

the counter medications



Gepetto always said his son had allergies, but the villagers knew better

It’s not your imagination. This is a particularly bad spring allergy season. We didn’t need media outlets to tell us that there are more itchy, sneezy, swollen eyed kids out there this year.

It is worth treating your child’s allergy symptoms- less itching leads to improved sleep, better ability to pay attention in school, improved overall mood, and can prevent asthma symptoms in kids who have asthma in addition to their nose and eye allergies.

Luckily, nearly every allergy medication that we wrote prescriptions for a decade ago is now available over-the-counter. As you and your child peer around the pharmacy through itchy blurry eyes, the displays for allergy

medications for kids can be overwhelming. Should you chose the medication whose ads feature a bubbly seven-year-old girl kicking a soccer ball in a field of grass, or the medication whose ads feature a bubbly ten-year-old boy roller blading? Its it better to buy a “fast” acting medication or medication that promises your child “relief?”

Here is a guide to sorting out your medication choices:

Oral antihistamines: Oral antihistamines differ mostly by how long they last, how well they help itchiness, and their side effect profile. During an allergic reaction, antihistamines block one of the agents responsible for producing swelling and secretions in your child’s body, called histamine. Prescription antihistamines are not necessarily “stronger.” In fact, at this point there are very few prescription antihistamines. The “best” choice is the one that alleviates your child’s symptoms the best. As a good first choice, if another family member has had success with one antihistamine, then genetics suggest that your child may respond as well to the same medicine. Be sure to check the label for age range and proper dosing.

First generation antihistamines work well at drying up nasal secretions and stopping itchiness but don’t tend to last as long and often make kids very sleepy. **Diphenhydramine (brand name Benadryl)** is the best known medicine in this category. It lasts only about six hours and can make people so tired that it is the main ingredient for many over-the-counter adult sleep aids. Occasionally, kids become “hyper” and are unable to sleep after taking this medicine. Opinion from Dr. Lai: dye-free formulations of diphenhydramine are poor tasting. Other first generation antihistamines include **Brompheniramine (eg. brand names Bromfed and Dimetapp) and Clemastine (eg. brand name Tavist)**.

Second and third generation antihistamines cause less sedation and are conveniently dosed only once a day. Cetirizine (eg.

brand Zyrtec) causes less sleepiness and it helps itching fairly well. Give the dose to your child at bedtime to further decrease the chance of sleepiness during the day. **Loratadine (brand name Alavert, Claritin)** causes less sleepiness than cetirizine. **Fexofenadine (brand name Allegra)** causes the least amount of sedation. The liquid formulations in this category tend to be rather sticky, the chewables and dissolvables are favorites among kids. For older children, the pills are a reasonable size for easy swallowing.

Allergy eye drops: Your choices for over-the-counter antihistamine drops include **ketotifen fumarate (eg. Zatidor and Alaway)**. For eyes, drops tend to work better than oral medication. Avoid products that contain vasoconstrictors (look on the label or ask the pharmacist) because these can cause rebound redness after 2-3 days and do not treat the actual cause of the allergy symptoms. Contact lenses can be worn with some allergy eye drops- check the package insert, and avoid wearing contacts when the eyes look red. Artificial tears can help soothe dry itchy eyes as well.

Allergy nose sprays: Simple nasal saline helps flush out allergens and relieves nasal congestion from allergies. **Flonase,** which used to be available by prescription only, is a steroid allergy nose spray that is quite effective at eliminating symptoms. It takes about a week until your child will notice the benefits of this medicine. Even though this medicine is over-the-counter, check with your child's pediatrician if you find that your child needs to continue with this spray for more than one allergy season of the year. Day in and day out use can lead to thinning of the nasal septum. Avoid the use of nasal decongestants (e.g., Afrin, Neo-Synephrine) for more than 2-3 days because a rebound runny nose called rhinitis medicamentosa may occur.

Oral Decongestants such as phenylephrine or pseudoephedrine can help decrease nasal stuffiness. This is the "D" in "Claritin D" or "Allegra D." However, their use is not

recommended in children under age 6 years because of potential side effects such as rapid heart rate, increased blood pressure, and sleep disturbances.

Some of the above mentioned medicines can be taken together and some cannot. Read labels carefully for the active ingredient. Do not give more than one oral antihistamine at a time. In contrast, most antihistamine eye drops and nose sprays can be given together along with an oral antihistamine.

If you are still lost, call your child's pediatrician to tailor an allergy plan specific to her needs.

The best medication for kids? Get the irritating pollen off your child. Have your allergic child wash her hands and face as soon as she comes in from playing outside so she does not rub pollen into her eyes and nose. know that spring and summer allergens/pollen counts are highest in the evening, vs fall allergies where counts are highest in the mornings. Rinse outdoor particles off your child's body with nightly showers. Filter the air when driving in the car and at home: run the air conditioner and close the windows to prevent the "great" outdoors from entering your child's nose. If you are wondering about current pollen counts in your area, scroll down to the bottom of many of the weather apps to find pollen counts or log into the American Academy of Allergy Asthma and Immunology's website.

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Contribute to our Two Peds Mother’s Day post!

Dr. Kardos, on a visit home from medical school, with her mom and grandmothers, 1991.

A flash of surprise spread across her face. “You mean my mother was right? I can’t believe it!” the mom in our office exclaimed.

Many times as we dispense pediatric advice, the parent in our office realizes that their own mother had already offered the same suggestions.

This Mother’s Day, we’re asking readers for anecdotes about times where maybe, just maybe, your mom or your grandmother was right after all. If you have a photo available of your mom or grandmother with your child that you don’t mind sharing as well, we would love to post them along with your anecdotes this Mother’s Day.

Please send them along to us at twopedsinapod@gmail.com before Mother’s Day weekend.

Naline Lai, MD and Julie Kardos, MD

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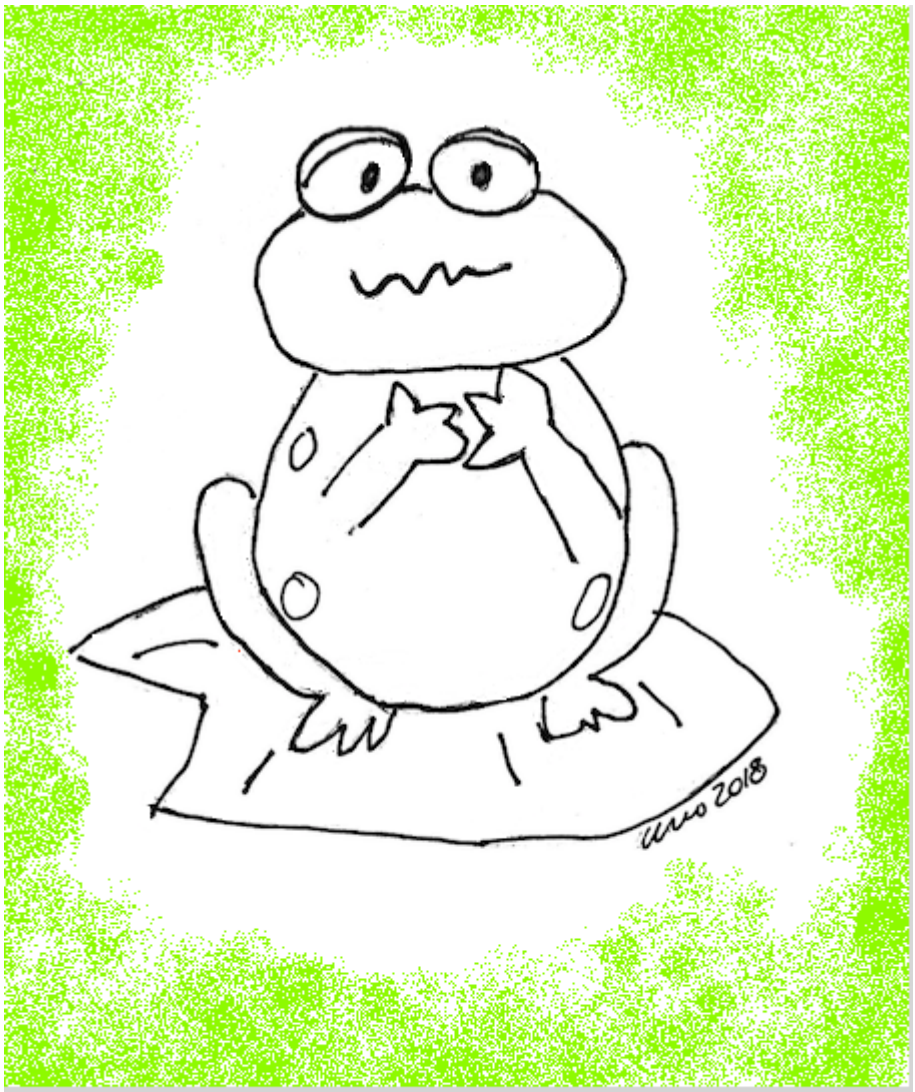
Does my child have strep throat?



Freddy the Frog didn't quite know how to describe the uncomfortable sensation in his throat.

The school nurse calls to say, “I have your child here with me and she has a sore throat. I think you should take her to the doctor to see if it’s strep throat.”

What IS strep throat?

Strep throat is a throat infection caused by Group A streptococcus (Strep pyogenes) bacteria. Symptoms can include sore throat, fever, pain with swallowing, enlarged lymph nodes (glands) in the front of the neck, headache, belly pain, vomiting, and rash. Not all symptoms are present in all kids with strep throat. Some kids look fairly ill and others with strep don't look too bad.

Kids with strep throat do NOT typically have cough, profuse runny nose, or diarrhea. Only about 15 percent of all kids coming to our offices with a main concern of "sore throat" actually have strep throat. That means that MOST kids with sore throats turn out to have something else, most commonly a virus.

Why do we care about strep throat?

Most children's immune systems are really good at fighting the strep germ. In fact, most kids would recover even if they were not treated. However, some kids' immune systems go a little haywire when fighting the strep germ. In addition to making antibodies (germ-fighting cells) to fight the strep, they make antibodies against their own heart valves (immune system gets confused). When antibodies attack the heart valve, kids can get rheumatic fever.

Treating strep throat with antibiotics shortens the duration of the illness by only about one day, but more importantly, treatment prevents the body from making the wrong kind of immune cells, or antibodies, against the heart valves. Fortunately, treating strep is not an emergency: starting antibiotics within NINE DAYS of symptoms is good enough to prevent rheumatic fever.

Strep throat can also lead to other complications such as scarlet fever (strep throat plus sandpaper-like rash on the

skin), peritonsilar abscesses (pus pocket in the tonsils) and kidney inflammation (first symptom can be cola-colored urine).

How do we know if your child has it?

To definitively diagnose strep throat , we use a long cotton swab to gently swipe the sore throat and obtain a sample of the germs. This sample goes to the laboratory to culture for Group A strep. In other words, we wait to see if the germ grows from the sample.

Doctors cannot diagnose strep throat over the telephone. Nor can doctors or nurses rely solely on physical exam findings, because while there is a “classic” look to strep throat, some kids with sore throats have normal appearing throats yet the test reveals strep. Others have yucky looking throats but in fact have some other viral infection. We physicians ask questions about your child’s symptoms and perform a thorough physical exam and then do a “strep test” if we suspect strep throat. Even doctors send their own children to the doctor for testing. Dr. Lai’s teen was just sent to her pediatrician’s office last week with a sore throat to check for strep the day before a track meet.

Isn’t there a quick way to know?

Many pediatric offices use rapid strep tests to help make a quick decision about treatment because the strep culture takes 48 hours or more to finalize. These rapid tests are fairly reliable, but sometimes can be negative (shows NO strep) even if strep is present, so most doctors send a culture back-up if the rapid test is negative. The other problem with the quick test is that once your child has strep, the quick test can stay positive for about a month, even if your child no longer has strep disease. So if a child is treated for strep throat and then develops another sore throat within a month of treatment, that child needs a strep culture back up if the office quick test is positive.

To further complicate matters, some kids “carry” the strep germ in their throats but never develop the disease (no sore throat or illness symptoms). These kids will test positive for strep but do not require treatment. This is why we do not routinely check kids for strep throat unless they have the typical symptoms. *Antibiotics come with their own risk of side effects so we want use them only when absolutely necessary.*

What is the proper treatment for strep throat?

The easiest way to treat strep throat is with the antibiotic amoxicillin, taken once daily, for ten days. Penicillin twice daily for ten days also treats strep throat but the liquid form doesn’t taste as good a amoxicillin so can be a little harder to give your kid. Your child’s pediatrician will prescribe one or the other. If your child is allergic to penicillin, your child’s doctor will prescribe a different antibiotic that is also effective.

My child was treated for strep throat. We finished the antibiotic. Three days later his sore throat is back. Why did this happen?

Most likely, your child contracted a new illness. The illness may or may not be strep again. Often the new sore throat is the viral-cold-of-the-day starting up. If your pediatrician determines that the sore throat is from strep, the most common reason for getting two episodes of strep throat close together is that your child contracted the germ again (usually from a classmate). It’s not that the antibiotic did not work. It’s just bad luck that your child got it again. Your child’s doctor can use the same antibiotic to treat the second strep or may opt to use a different one.

Fortunately, strep throat has not shown much, if any, resistance to standard antibiotic therapy. The reason that we treat children (and adults) for a full course of antibiotic is that this duration helps prevent complications. You should give your child the complete course of antibiotic her health care provider prescribes, even if she feels better part way through the treatment. In addition to treating with antibiotic, be sure to provide pain medicine such as acetaminophen (eg. Tylenol) or ibuprofen (eg. Motrin or Advil). Here are more suggestions to treating sore throat pain. Good news: after 12 to 24 hours after the first dose of antibiotic, your child is no longer contagious. If they feel better, they can return to school after this time.

Contact your child's doctor during treatment if your child experiences increasing pain, inability to swallow, seems dehydrated, or look worse instead of better.

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Getting meds in: How to teach your child to swallow pills, give eye drops and other tips

Does your kid spit out medicine? Clamp her jaws shut at the sight of the antibiotic bottle? Refuse to take pain medicine when she clearly has a bad headache or sore throat?

The python pediatrician always found that her patients, especially the kids from the Giraffe family, were initially hesitant about swallowing pills.

Sometimes medicine is optional but sometimes it's not. Here are some ways to help the medicine go down:

Don't make a fuss. We mean PARENTS: don't make a fuss. Stay calm. Explain that you are giving your child medicine "for your sore throat," for example. Calmly give her the pill to swallow or the medicine cup or syringe filled and have her suck it down, then offer water to drink. If you make a BIG DEAL or warn about the taste or try to hurry your child along, she may become suspicious, stubborn, or flustered herself. Calmness begets calm.

What if she hates the taste?

- Most medication can be given with a little chocolate syrup or applesauce (yes, Mary Poppins had the right idea). Check with your child's pharmacist if your child's particular prescription can be given this way.
- Often, your pharmacist can add flavor to your child's

prescription.

- Check if your child's medicine comes in pill form so she doesn't have to taste it at all.
- Try "chasing" the medicine down with chocolate milk instead of water to wash away a bad taste quicker.
- Use a syringe (no needle of course) to slowly put tiny bits of liquid medicine in the pocket between her outer teeth and her cheek. Sooner or later she will swallow. After all, she swallows her own saliva. (A factoid: an adult swallows up to 1.5 liters of saliva a day.)

DO NOT mix the medication into a full bottle or a full cup and expect that your child will finish it all. There is a good chance that the child will not finish the bottle and therefore not finish the medication. If mixing into a liquid, better to suck up the medicine into a measuring syringe and then, if needed, suck up an addition little bit of juice or Gatorade to attempt to hide the flavor and get the full dose in at once.

WHAT IF SHE THROWS UP THE MEDICATION? Call your child's doctor. If the medication was not in the stomach for more than 15 minutes, we will often not count it as a dose and may instruct you give another dose.

WHAT IF SHE CAN'T SWALLOW PILLS? If your child can swallow food, she can swallow a pill. Dense liquids such as milk or orange juice carry pills down the food pipe more smoothly than water. Start with swallowing a grain of rice, a cake sprinkle, or a tic-tac. For many kids, it is hard to shake the sequence of biting then swallowing. Face it. You spent a lot of time when she was toddler hovering over her as she stuffed Cheerios in her mouth, muttering "bite-chew-chew-swallow." Now that you want her to swallow in one gulp, she is balking. Luckily, most medication in pills, although bitter tasting, will still work if you tell your child to take one quick bite and then swallow. The exception is a capsule. The gnashing of little teeth will deactivate the microbeads in a capsule release system. If you are not sure, ask your pharmacist.

WHAT IF ALL ATTEMPTS AT ORAL MEDICINE FAIL? Talk to your child's doctor. Some liquid antibiotics come in shot form and your pediatrician can inject the medicine (such as penicillin), and some come in suppository form; Tylenol (generic name acetaminophen) is an example. You can buy rectal Tylenol if sore throat pain or mouth sores prevent swallowing or if your child simply is stubborn. Sometimes you just have to have one adult hold the child and another to pry open her mouth, insert medicine, then close her mouth again.

HAVE AN EAR DROP HATER? First walk around with the bottle in your pocket to warm the drops up. Cold drops in an ear are very annoying. (In fact, if cold liquid is poured into the ear a reflex occurs that causes the eyes beat rapidly back and forth). Use distraction. Turn on a movie or age-appropriate TV show, have your child lie down on the couch on her side with the affected ear facing up. Pull the outside of her ear up and outward to make the ear opening more accessible, then insert the drops and let her stay lying down watching her show for about 10 minutes. If you need to treat both ears, have her flip to the other side of the couch and repeat. Another option: treat your child while she sleeps.

AFRAID OF EYE DROPS? If your child is like Dr. Kardos who is STILL eye-drop phobic as a grown-up, try one of two ways to instill eye drops. Have your child lie down, have one person distract and cause your child to look to one side, insert the drop into the side of the eye that your child is looking AWAY from. She will blink and distribute the medicine throughout the eye. Alternatively, have your child close her eyes and turn her head slightly TOWARD the eye you need to treat. Instill 2 drops, rather than one, into the corner of her eye nearest her nose. Then have her open her eyes and turn her head slowly back to midline: the drops should drop right into her eye. Repeat for the second eye if needed.

HATE CREAM? Some kids need medicated cream applied to various skin conditions. And some kids hate the feeling of goop on

their skin. These are often the same kids who hate sunscreen. Again, distraction can help. Take a hairbrush and “brush” the opposite arm or some other area of the body far away from the area that needs the cream. Alternatively, apply the cream during sleep. Another option- let your child apply his own cream- this gives back a feeling of control which can lead to better compliance with medicine. It also will help him to feel better faster. IF your child is complaining about stinging, try an ointment instead. Ointments tend to sting less than creams.

Of course, as last resort, you can always explain to your child in a logical, systematic fashion the mechanism of action of the medication and the future implications on your child’s health outcome.

If you choose this last method, you should probably have some Hershey’s syrup nearby. Just in case.

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