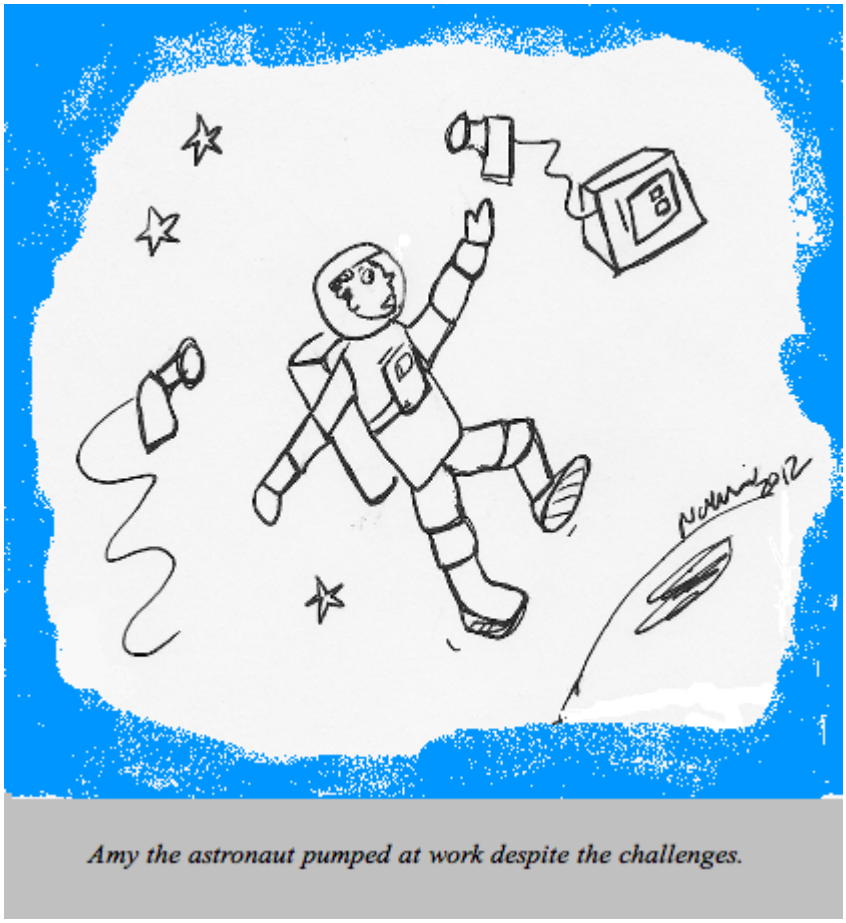
Pump it up: breastfeeding and returning to work



Amy the astronaut pumped at work despite the challenges.

Picture this: you are going back to work after a too-short maternity leave. Briefcase? Check. Lunch? Check. Breast pump? Check. Photo of your baby to put on your pump for inspiration? Check.

Many moms ask how to continue breastfeeding when they return to work. Because babies should receive breast milk or formula for at least their first year, here is how you can incorporate breastfeeding into your work routine:

Offer bottles by four weeks of age. Bottles can contain breast milk or formula, but you need to give your baby practice taking milk from a bottle by four weeks old. If you wait much longer, your baby will likely refuse the bottle. Have someone other than yourself give at least one bottle per day or every other day. In this way, your baby learns to accept nutrition

from someone else.

Store breast milk using the simple and conservative “rule of twos.” Leave breast milk in a bottle at room temperature for no more than two hours, store breast milk in the refrigerator for no more than two days, and store in the freezer for no more than two months. If your baby has already sucked out of a breast milk bottle, that milk is only good for up to two hours. Remember to write the date on your milk storage bags and use the oldest ones first.

Now select from the following breast feeding menu, understanding that you might start with option 2 or 3 and then change to option 4. The best option is the one that works best for you and your baby.

Option 1: Continue to breast feed at work. This option works for moms who work from home, moms who have child care in their work setting, and moms close enough to dash home to breast feed during the day or who have caregivers willing to drive babies over to work for feedings.

Advantage: no pumping, no buying formula, no bottle washing. **Disadvantage**: may require some creative scheduling.

Option 2: **Breast feed when home and pump and store breast milk at work**. Have child care givers offer stored breast milk in bottles. This method allows moms to provide exclusively breast milk to their babies. Start pumping after the first morning feeding (or any other feeding that you feel you produce a bit more than your baby needs for that particular feeding)

beginning when your baby is around four weeks old. Also pump if your baby happens to sleep through a feeding. Store this milk in two or three ounce amounts in your freezer. You can obtain breast milk freezer bags from lactation consultants and baby stores, or you can store milk in zip lock bags. As you continue to pump after the same feeding each day, your body will produce more milk at that feeding.

Once you have some breast milk stored and you are a few days out from returning to work, try pumping during the feedings you will miss while at work. Have someone else feed your baby breast milk bottles for these feedings. Finally, when you return to work, continue to pump at the same schedule and leave the stored breast milk for your child's caregivers. Consider leaving some formula in case caregivers run out of breast milk. Remind them never to microwave the milk (this kills the antibodies in breast milk as well as creates a potential burn hazard) but rather to thaw the milk by placing in a hot water bath.

This method becomes easier as babies get older. Once babies start solid foods, they breast feed fewer times per day. Somewhere between six to nine months, your baby eats three solid food meals per day and breastfeeds four or five times per 24 hours. Thus, the number of times you need to pump decreases dramatically.

Advantage to this option: breast milk with its germ-fighting antibodies given through the first year and no expense of formula. **Disadvantage**: having to pump at work.

Option 3: Breast feed before and after work and give your baby

formula while you are at work. If you do not pump while at work, your body will not produce milk at these times. If you work full time, then on weekends you might find it easiest on your body to continue your “work time” feeding schedule. If you choose this method, wean your baby from daytime breast feeding over that last week or so before returning to work. Suddenly going a long time without draining your breasts can lead to engorgement, subsequent plugged ducts, and mastitis.

Advantage: baby continues to receive breast milk. No need to pump at work. **Disadvantage**: you still have to wash bottles and have the added cost of formula.

Option 4: Breast feed until you return to work, then formula feed. Wean over the last week you are home with your baby to avoid engorgement and leaking while at work. Your baby still benefits from even a few weeks of breast milk.

Advantage: No need to incorporate pumping into your work schedule. Baby still gets adequate nutrition. **Disadvantage**: babies who are in childcare and exposed to many germs miss out on receiving extra antibodies in breast milk. However, weaning your baby off breast milk will not cause illness. Do what works for your family. Also, more expensive to buy formula and time-consuming to wash bottles.

Pumping should not take longer than 15 minutes if you’re pumping both breasts at the same time and can take as short as 7-10 minutes. Remember to wash your hands before pumping.

What kind of breast pump should you buy/rent? If you are in it

for the long haul, we recommend the higher-end electric double pumps with adjustable suction. Ask the hospital nurses, your midwife, or your obstetrician for names of people who rent or sell pumps in your area.

Finally, remember that the calorie count and nutritional content of breast milk and formula are the same. So do NOT feel guilty if pumping does not pan out and you and end up giving some formula. Your baby is almost always going to be more efficient than a breast pump and some breasts just don't produce milk well during pumping sessions. In contrast, some of my patients never got the hang of breast feeding and their moms pumped breast milk and bottle fed them for the entire first year. Dr. Lai and I have each had patients who refused to take a bottle at childcare but just waited patiently for their moms to arrive. These babies got what they needed by nursing throughout the night. The babies didn't mind what time of day they ate. Just like many aspects of parenting, sometimes with breast feeding, you just have to "go with the flow."

Julie Kardos, MD with Naline Lai, MD

Traveling With Children

As I pack for an upcoming family vacation, I am reminded of the numerous questions over the years that parents have asked me about traveling with children. Often they ask, what is the best way to travel that will allow everyone to enjoy the vacation?

Ha,ha, I think to myself. The real answer is to hire a sitter or enlist grandparents to babysit and leave the kids at home. My husband and I always refer to family vacations as “family displacements.”

No, really, family vacations are wonderful experiences as long as you hold realistic expectations. First you have to get there.

Easier said than done.

When traveling by air, parents wonder if they should bring a car seat for the plane. Young children who sit in a car seat in the car should sit in a car seat in an airplane. Unfortunately, not all car seats fit into the airplane seat properly. The best advice I can give is to bring your car seat and make an attempt to fit it properly. If it doesn’t fit properly, you will still need it for the car ride from the airport after you arrive at your destination. Not all car rental facilities provide car seats.

Another question I am frequently asked about long plane rides is “Should I give my child Benadryl (diphenhydramine) so he/she will sleep through the flight?” Unfortunately, Benadryl’s reliability as a sleep aid is spotty at best. Most kids get sleepy, but the excitement of an airplane ride mixed in with a “drugged” feeling can result in an ornery, irritable child who is difficult to console. I advise against this practice. On the other hand, Benadryl can help motion sickness and is shorter acting than other motion sickness medications.

Ear pain during an airplane’s descent is also a common worry. Yes, it is true that ears tend to “pop” during the landing as the air pressure changes with altitude. Some young children (and their parents) find this sensation very unpleasant. However, most babies are lulled to sleep by the noise and vibration of an airplane and are unaffected. If

your child is safely in a car seat, I do not advise taking him out of it to breastfeed during landing. Offer a pacifier if you feel he needs to suck/swallow during the landing, and offer an older child a snack so she can swallow and equalize ear pressure if she seems uncomfortable during the landing.

Speaking of food, try to carry healthy snacks rather than junk food when traveling. Staying away from excessively salty or sweet food will cut down on thirst. Also, keep feeding times similar to home schedules in order to prevent toddler meltdowns.

Remember that young children hate to wait for ANYTHING and that includes getting to your destination. Bring along distractions that are simple and can be used in multiple ways. For example, paper and crayons or pencils can be used for: coloring, drawing, word games, origami, tic-tac-toe, math games, etc.

When traveling internationally, check the Center for Disease Control website www.cdc.gov for the latest health advisories for your travel destination. Do your research several weeks in advance because some recommended vaccines are available only through travel clinics. Also, some forms of malaria prevention medicine need to be started a week prior to travel.

Please refer to our “Happy, Healthy Holiday” blog post from 12/10/2009 for further information about keeping kids on more even keel during vacations. In general, attempt to keep eating and sleeping routines as similar to home as possible. Also remember to wash hands often to prevent illness during travel. Finally, locate a pediatrician or child friendly hospital ahead of time in case illness does strike. Unfortunately, most illnesses cannot be diagnosed by your child’s health care provider over the phone.

While traveling with young children can seem daunting, the memories you create for them are well worth the effort. And it DOES get easier as the kids get older. Now I can laugh at the image of my husband with two car seats slung over his back lugging a large diaper bag and a carry-on, leading my preschooler struggling with his own backpack filled with snacks and air plane distractions, while I am balancing

two non-walking twin babies, one in each arm, as we all take our shoes off for the airplane security checkpoint.

We've come a long way, and so can you. Happy Travels!

Julie Kardos, MD with Naline Lai, MD

"There's a monster under my bed": all about nightmares, night terrors, night wandering and bedwetting

Just last night my ten year old sounded the "MOMMY, MOMMY!!!" alarm in the middle of the night. Almost without opening my eyes I went to his room and calmly walked him to the bathroom where he emptied his bladder with gusto and went right back to bed. Witness: A nightmare with a purpose.

Ever wonder when you, the parent, get to sleep through the night? Now that your child has graduated from the crib, tune into this podcast to learn how to handle situations that sabotage sleep in children: nightmares, night terrors, night wanderings, and bedwetting.

https://www.twopedsinapod.org/wp-content/uploads/2014/09/Theres-a-monster-under-my-bed__-all-about-nightmares-night-terrors-night-wandering-and-bedwetting.mp3

Julie Kardos, MD and Naline Lai, MD

How to Help Your Bedwetting Child

“Help, Mommy, Daddy, I wet the bed!”

As you wash yet another set of bed sheets and wet pajama bottoms, you may be wondering WHEN your child will stay dry at night and WHY your child still wets the bed when his friends, or worse yet, his younger siblings, are dry. This post addresses primary bedwetting (doctors call this “primary nocturnal enuresis”), kids who have NEVER been dry at night. Children who have had months or years of dry nights and then start bedwetting consistently should go see their pediatrician to rule out medical causes of new bedwetting.

Here are a few things parents of bed-wetters should know.

Most children master staying dry during the **day** BEFORE staying dry during the night. Only a small number of children actually wake up dry in the morning before they start potty training. Daytime dryness is under your child's cognitive control. Night time dryness is not learned or controlled by your child's rational brain, but rather is a function of your child's bladder being mature enough to send a WAKE UP!! signal to your child. Quick hint here: nightmares can result from a full bladder. As you comfort your child from a bad dream, don't forget to take him to the bathroom.

About 80 percent of children are dry overnight by age four. They sleep through the night and wake up dry or they wake up once to urinate in the bathroom and go back to bed. What about the other 20%? Each year after age four years, about 10% of kids who are wet at night become dry without any intervention. Genetics play a big role in this. If one parent was a bedwetter until age 7, for example, then the child has a 35% chance of bedwetting until this age. If both parents wet the bed until school age, then their child has at least an 80% chance of being just like Mom and Dad.

However, some kids just wet the bed even though their parents were dry at an early age. Regardless, parents can help.

- **Do NOT punish your child for wetting the bed**. It truly isn't his fault.
- It is reasonable to **limit fluid intake** in the few hours before bed but do allow your child to drink water if thirsty or with teeth brushing.
- By all means **let your child wear training pants at night or at least put some form of water repellent**

mattress protector on your child's bed. These are not "crutches" or "enablers" but rather save you from having to wash sheets and mattresses.

- Not all kids are actually upset about bedwetting, but they can become very upset if parents let them feel that way. **Reassure your child** that someday "the pee pee will wake you up to go potty in the night" just like it tells your child to go to the bathroom during the day.

Older kids might become self-conscious, and their self-esteem gets impacted by their bedwetting. Typically this happens between the ages of 8 to 10 years, when sleep-overs and camp gain popularity.

Ways to help your child approach potentially awkward situations include:

- Have the sleep-over at your house and have our child's absorbent training pants already in the bed hidden under the covers. Your child can put them on after "lights out."
- Tell your child that he does not have to share the reason for not wanting to sleep away from home.
- Alternatively, he can tell his friends that YOU, the mean parent, will not allow him to attend sleepovers yet.
- If your child is motivated to try to become dry overnight, you can try a bed wetting alarm system. These systems work well over a period of several months. With alarms, both parents and children have to be active participants.

Additionally, there is one medical option.

Talk to your child's health care provider about medicine called DDAVP that can give a "quick fix." The medication can

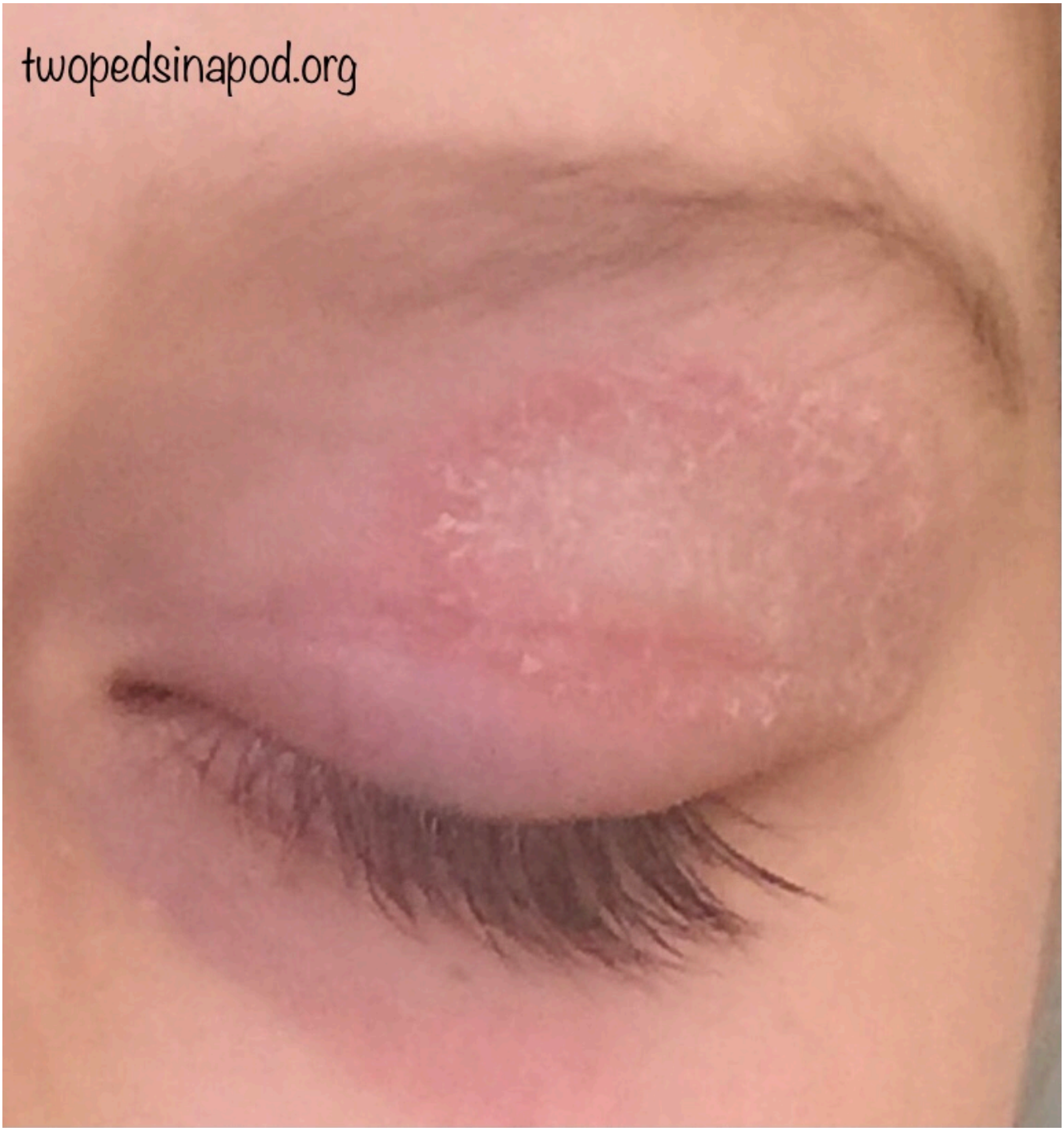
keep your child dry on the night he takes the medicine. The medicine comes in pill form. Your child could either take it only for sleepovers or can take it for a few months at a time if bedwetting compromises his self-esteem. Note that even after months of dry nights on medicine, your child will likely bed wet if he stops taking the medicine. However, there is also a chance that nature will have taken over and by the time the medication is stopped, your child will have reached the age that his body was programmed to stay dry at night.

Of course, your child's health care provider can help ensure that your child merely has an immature bladder-to-brain messaging system and not any other cause of his bed-wetting. Your doctor can also help evaluate if your child's self esteem is affected by his bedwetting.

While not the most glamorous part of the parenting game, washing up after a bedwetting child and keeping a positive attitude for him are very important. The next time you will play this supportive role is when you become grandparents and your former bedwetter calls you for advice about his own bedwetting child.

Julie Kardos, MD and Naline Lai, MD

What do ringworm, jock itch, and athlete's foot all have in common?



Ringworm can appear anywhere there is skin- even on the eyelid.

What do ringworm, jock itch, and athlete’s foot all have in common? They are all names for the same type of fungal infection- just in different parts of the body.

These infections, caused by fungi called dermatophytes, fall into the mostly-harmless-but-annoying category of childhood skin rashes. Ringworm (tinea corpus), occurs on the body. Athlete’s foot (tinea pedis) occurs on feet, and Jock itch (tinea cruris) occurs in the groin area.

The name “ringworm” comes from one of the typical appearances of a dermatophyte rash. Often, there is a pinkish, slightly raised ring around an oval patch of flesh or light-pink colored, slightly scaly skin. Sometimes the patch is slightly itchy, but not as itchy as allergic reactions like insect bites.

Diagnosis

Your child’s doctor diagnoses the rash by examining your child’s skin. To treat the rash, apply the recommended antifungal medication until the rash is gone for at least 48 hours (about two to three weeks duration). Clotrimazole (brand name Lotrimin -NOT Lotrimin Ultra) is over-the-counter and is applied twice daily. You will find it in the anti-athlete’s foot section, but you can apply it to skin on any part of the body.

> *On the scalp, ringworm causes hair loss where the rash occurs and treatment is not so straightforward.*

On the scalp (tinea capitis), ringworm causes hair loss where the rash occurs and treatment is not so straightforward. Often the area has tiny broken hairs and some scale. Ringworm on the scalp requires a prescription oral antifungal medication for several weeks. The fungus on the scalp lives not only on the skin, but also in hair follicles. So, topical antifungals fail to reach the infection. Your doctor will also suggest a shampoo which will not kill the fungus, but will temper any spread.

Sometimes a specimen is sent for lab testing- one part called a KOH stain comes back quickly, but is not definitive. The fungal culture is a better test but can take several weeks to return.

Spread

Dermatophytes generally spread through direct contact. Wrestling teams are often plagued with this infection. The furry friends your child sleeps with may also carry ringworm. If Fido, the dog, or Fi-fi, the cat has patches of hair loss, take them to the vet for diagnosis. Less often, dermatophytes are picked up through indirect contact such as walking barefoot on locker room floors.

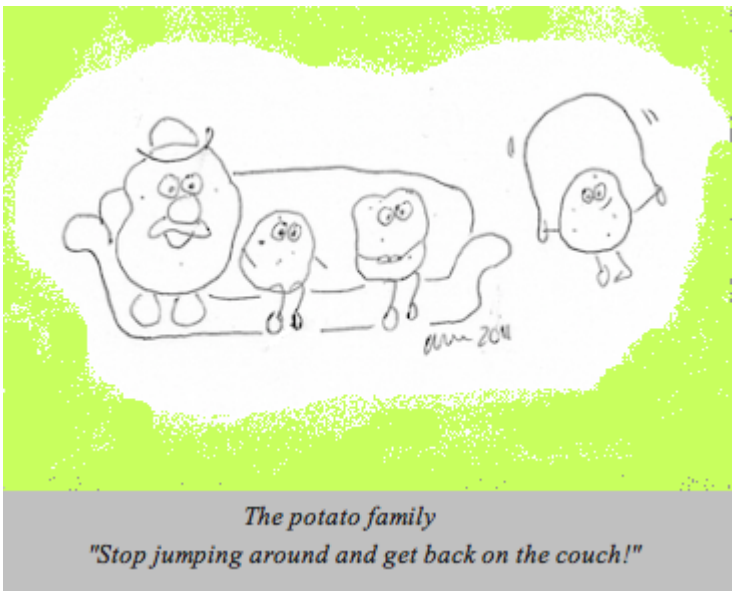
If there is no improvement after a week or so of treatment, have your child's doctor reexamine the rash. Other diagnoses we keep in mind include eczema and granuloma annulare. And if the rash continues to enlarge and is flat, we consider Lyme.

Kids are allowed to attend school and daycare with ringworm once treatment is started, but wrestlers are advised to treat for 72 hours on skin and 14 days if on the scalp prior to returning and to cover any rash.

Luckily the fungus among us rarely gets humongous!

Naline Lai, MD and Julie Kardos, MD

Quick exercises for kids and teens



Physical therapist Dr. Deborah Stack brings us quick exercises for kids and teens – Dr. Lai and Kardos

After six months of COVID; yes, it really has been that long already, your family has probably found some favorite outdoor hiking spots or bike routes. But what can you do when it's too cold or wet outside? How can you combat literally HOURS of kids sitting at computers especially if they only have 30-45 minutes until their next class? Here are quick exercises for kids and teens and a table of caloric expenditure for common activities.

Schedule active movement breaks into their day. Take advantage of that lunch and recess "break" and be an example yourself.

Here are some short burst ideas:

- Have a 15-minute dance party
- Use your body to make all the letters of the alphabet
- Shadow box to some music
- Dust off the treadmill or stationary bike in the basement
- Play ping-pong
- Do a few chores (carrying laundry baskets up and down is great exercise)

- Jump rope
- Jog in place
- Do jumping jacks
- Pull out some “little kid games” such as hopscotch or hulahoop
- Let each child in your house choose an activity for everyone to try
- Do a family yoga video
- Walk or “run” stairs…kids can try to beat their prior score for a minute of stairs
- Take walking/wheeling/even wheelbarrow laps around the house
- Stretch out calves, quadriceps, arms and back…see ergonomics post for counteracting all the sitting

Don’t forget the teenagers; they still need activity too especially if their teams are not practicing or competing. Staff from the Mayo Clinic recommend kids ages 6-17 should have one hour of moderate exercise each day. Exercise can help improve mood (through the release of endorphins), improve sleep and therefore attention (critical with all the online learning), and improve cardiovascular endurance. Here are some numbers to get the kids moving:

All activities are based on 20 minutes and a teen who weighs 110 pounds. The number of calories burned depends on weight. If your child weighs more, he will burn a few more calories, if he weighs less, he’ll burn a few less. Below the table are links to some free and quick calorie calculators on the web so your kids can check it out for themselves. For those attached to their phones, there are web apps too.

ACTIVITY	CALORIES USED
Shooting Basketballs	75

Pickup Basketball game/practice	100
Biking on stationary bike	116
Dancing	75
Hopscotch	67
Ice Skating	116
Jogging in place	133
Juggling	67
Jumping Rope	166
Ping Pong	67
Rock Climbing	183
Running at 5 mph	133
Sledding	116
Treadmill at 4 mph	67
Vacuuming	58

caloriesperhour

Try these activity calculators:

http://www.caloriecontrol.org/healthy-weight-tool-kit/lighten-up-and-get-moving

https://www.webmd.com/fitness-exercise/healthtool-exercise-calculator

Keep ’em moving- you’ll have more fit, better rested, and happier kids!

Deborah Stack, PT DPT PCS

Dr. Stack is a board certified specialist in pediatric physical therapy and the owner of the Pediatric Therapy Center of Bucks County, LLC in Doylestown, PA. In addition to treating children ages 0-21 for conditions such as torticollis, coordination, neurologic and orthopedic

disorders, she also instructs physical therapists across the country in pediatric development and postural control and is a Certified Theratogs fitter.

The winter cold virus

Believe it or not, pharmacies sold this “cold remedy” until the 1960s!

Honey, tar, and alcohol, oh my! Tucked away in a display at the Mercer Museum of Bucks County, Dr. Lai found this old bottle of cough syrup from the late 1800s. While we do NOT recommend this type of medicine for children of any age for

any condition, it does remind us that we wish we had the perfect cold remedy to offer our patients who have a winter cold virus.

Whether your child caught their cold from the infant room in daycare or the high school hallway during change of class time, kids with colds suffer similar symptoms in a similar time course.

Kids can start out feeling extra tired or out of sorts for a day or so, then they may develop a sore throat, runny nose, maybe a fever, and then the cough sets in. Fever from a cold virus starts within the first two days of a cold. Younger kids sometimes develop loose bowel movements or vomit mucus. Colds can cause watery eyes. Symptoms from a winter cold virus interrupt sleep and disrupt appetites.

What can parents do to help their children feel better from a winter cold virus?

- Treat pain from sore throats, nasal congestion, or mild aches with acetaminophen (Tylenol) or ibuprofen.
- Treat fever if it is causing discomfort, again with acetaminophen or ibuprofen.
- Use nasal saline to treat stuffy noses. Because babies can’t blow their noses, you can suction the mucus out to help them breathe better through their noses. Older kids can try to blow their noses to clear them. Steam from a hot shower can help clear out stuffy noses as well– read their bedtime story in the steamy bathroom or give them an extra bath.
- Coughing is normal with a cold. In kids over one year of age, honey can soothe a cough. In all kids, drinking

extra fluids to moisten the throat will help suppress cough. Cough medicine doesn't work well and the American Academy of Pediatrics does not recommend cough medicine for kids under 4 years. The cough medicine you can find on pharmacy shelves can have side effects and does not improve symptoms. However, if your child's cough is from asthma, be sure to follow their asthma care plan to keep their airways open.
- All kids need extra fluids when sick: encourage lots of drinking.

It can take 2-3 weeks for ALL symptoms of a cold to resolve. However, kids usually feel their worst during the first week. If they are not feeling too miserable, they can still go to school. Keep your child home from school if they require too much TLC for a teacher to provide while caring for everyone else in the class. Older kids should stay home if they feel too tired or miserable to learn. Having trouble getting an older kid to pack a water bottle and go to school? Just remind them, "There is nothing wrong with your brain…just your nose."

Most kids with colds never need a doctor visit. However, here are reasons to call your child's pediatrician:

- Cough makes your child short of breath.
- Initial fever of 100.4 or higher lasts more than 2-3 days.
- All babies 8 weeks or less go to the Emergency Department for ANY temperature of 100.4 (rectal) or higher.
- Fever suddenly appears "just as you thought things were turning the corner and improving."
- Your child does not drink enough to urinate their typical amount per day.
- Runny nose and cough show NO signs of improvement by the

end of 2 weeks.
- Symptoms continue to get worse and worse, instead of better, after the first week.
- Watch for pain. Depending on location, pain can be a sign of a new bacterial infection on top of a cold virus. For example, ear pain can signify an ear infection, chest or shoulder pain can signify pneumonia, and pain over the face (cheeks or forehead or behind the nose) can signify a sinus infection.

How to keep from getting a winter cold virus? Wash your hands, wash your kids' hands, and did we remember to say "wash hands?" Remember to get everyone in your family the flu vaccine, because the flu is MUCH WORSE than a cold, and you already know how miserable a cold can make your child feel.

And please do NOT use the cold remedy in the photo that Dr. Lai took at the museum. Better to ride out the winter cold with "tincture of time," and chicken soup.

Julie Kardos, MD and Naline Lai, MD

Help prevent your teen from playing risky games

Some games are riskier than others and it’s hard for teens to tell the difference.

Remember playing “Truth or Dare” as a kid? Some of the dares were silly, some potentially embarrassing, but some were downright risky. Now our children are playing potentially dangerous games. How can you prevent your teen from taking unnecessary risks?

To understand why kids would play risky games such as the Cinnamon Challenge or the Laughing Game, let’s step into the mindset of a teenager. Don’t let their adult-like appearances deceive you. Based on what we know about teenage brain development, teens are more likely to misinterpret or mislead social cues and emotions and to engage in risky behavior. Even though your teens may be taller than you, their deductive reasoning skills are not fully developed until around 25 years old. They have difficulty thinking through long term plans.

Take a simple example of studying. If they stay up very late studying, they do not consider that this will cause impairment in cognition the next day and consequently they are forced to stay upeven later to understand class material. Further, because teens also are impulsive, they will typically check their cell phones multiple times while studying, which further pushes off bedtime. Days later, when it comes to taking a test in class, their cumulative sleep deprivation leads to poor focus and poor memory retrieval.

Applied to more dangerous situations and coupled with peer pressure, even a “good teen” may take unnecessary risks. Teens truly believe that they cannot die. Even if they know others who have died, they don’t think it can happen to them. So they may be more likely to run across a busy street, try getting high off of a friend’s Adderall, or drive distracted while checking social media on their phones.

Teen peer pressure + immature teen brain = disaster potential.

As parents, you do have some power to prevent disaster. You can teach your teens the tools you have acquired through the years to help them consider all potential consequences of their actions.

Here are some ways parents can teach:

- Tell kids to pause first before playing any game. Think “What is the worst that can happen if I play the game, win or lose?” If the worst case scenario is severe injury or death, DON’T PLAY THE GAME. Remember that kids feel invincible.
- Teach directly by allowing kids to take small risks. Like we’ve said before, hold tight, but remember to let go. If your child chooses not to study for a test in school, then let them fail the test. However, make sure they study for the final exam.
- Teach indirectly through anecdotes, either from your own

childhood or events you hear about. For example, your kids might not consider that the beach they visit with you every summer can hold danger. Tell them about the family I know who lost their teen to drowning while swimming too far and was caught in a riptide on an unguarded beach.

- Teach kids that you cannot always save them. You cannot magically can save them if they get hit by traffic on a dare.
- Know where your kid and your kid's friends are developmentally and supervise accordingly. Volunteer to host the gatherings where a game may occur. Hint: Go down into the basement often with food-the kids will be happy to see you and you can be a better spy.
- Keep 'em busy so that they do not play risky games simply out of boredom.
- Give your kid a way out of an uncomfortable situation. Let them know they can always say, "I can't, my parents would kill me."

Unfortunately life is not all fun and games. Remind your kids that playing Monopoly or video games is not the same as taking real life risks.

Julie Kardos, MD and Naline Lai, MD

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.

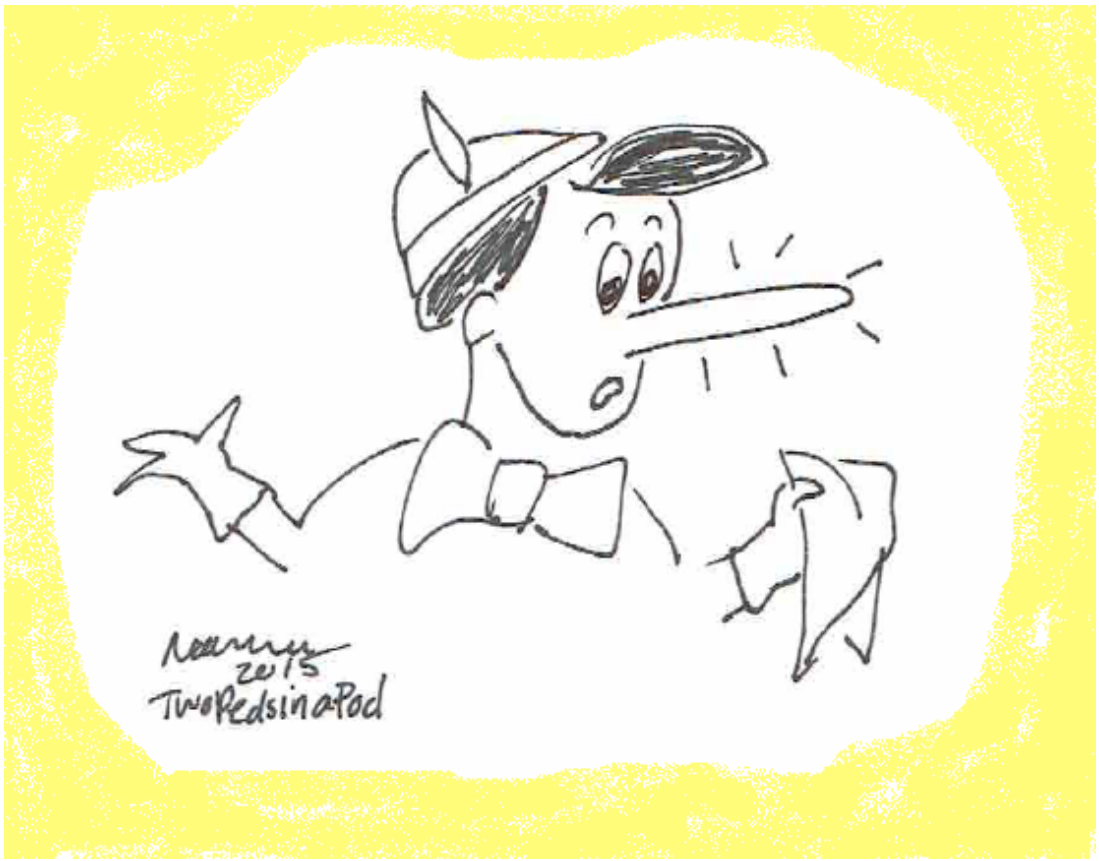
Generally, any poison ivy rash which is in the area of the eye

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.

Naline Lai, MD and Julie Kardos, MD

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 improvedsleep, 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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