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

*_Red Book_, 2015 Report of the Committee on Infectious Diseases, American Academy of Pediatrics

Mom, thanks for every “I told you so”

Melanie with grandma and mom

Now that you are a mom, maybe, just maybe, you realize that your grandmother or mom was right after all. We asked our readers for some examples and our friend, writing coach Melanie Cutler, told us about two generations of advice she wishes she had heeded:

Grandma Helen ALWAYS had unsolicited advice for whoever would listen. She clipped out magazine articles and mailed them to her children and grandchildren. She was very well-read, and she knew a thing or two about most things nutrition and health-related. We found it annoying at the time, but looking

back, she was right– and way ahead of her time in many respects.

About all of it.

Staying out of the sun, wearing sunscreen anyway, improving my posture, rinsing fruits and vegetables, and wait, did I mention staying out of the sun? She knew that you shouldn't eat the skin of the potato, but that the nutrients are right up against the skin, so you should nibble all the way to the skin. Likewise, she knew that the most nutritious part of the apple was the skin. That it isn't healthy to drink too much during meals because it interferes with digestion. She told me to hold in my tummy when I was just standing there because it was good exercise. Oh, how I wish I had listened….

I also wish I had obeyed when my mom, Joan, told me to stand up straight, put my backpack on both shoulders (despite the current fad), wear sunscreen, learn to play the harmonica, and worry less. She didn't dispense as much overt advice as her mother, Helen– probably because we were all duly hounded by Grandma ;-).

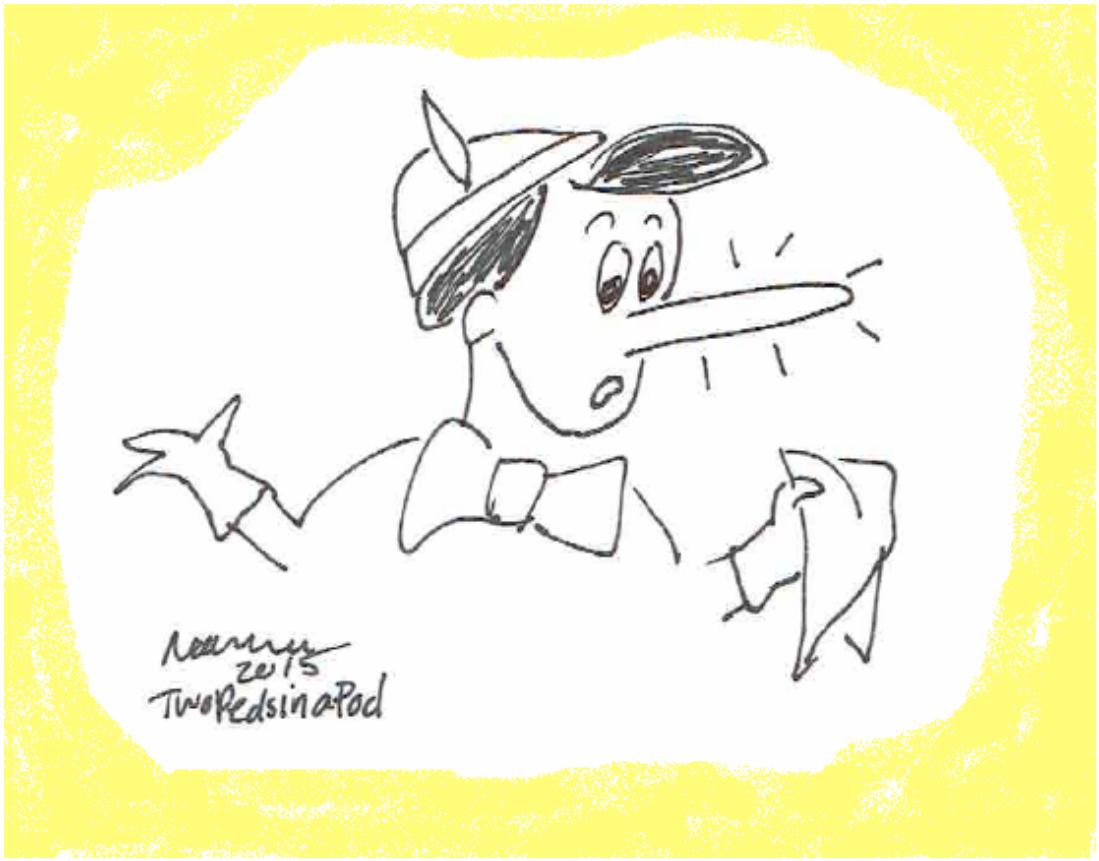
Although my back is a bit crooked and I am covered with freckles, it's never too late to heed their advice.

Maybe I'll take up the harmonica.

Mothers everywhere, thanks for every "I told you so" you've uttered. Keep giving us your advice, no matter how big we get and even if it doesn't seem like we are listening.

Julie Kardos, MD and Naline Lai, 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 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.

Naline Lai MD and Julie Kardos, MD

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

I have autism

To complete our autism awareness month posts, the following is a speech that a friend of Dr. Kardos's with autism gave to his classmates a few years ago when he was fifteen.

Good morning everybody. Today, I wanted to talk to you about Autism. I have Autism . Don't worry, it's not something you can catch from me… it's not a like a virus or anything like that. When I was very young, a doctor diagnosed me with Autism. My parents took me to the doctor because I didn't talk much – I talked a lot less than kids were supposed to. Actually, I still talk a lot less than other kids.

A lot of people think things about Autism that just aren't true. They really shouldn't because everybody is different and has different things they do well. Actually, I am pretty smart. So are a lot of my friends with Autism. I just have a hard time with words. So reading, writing, and speaking are kind of hard, but I'm very good at math, science and stuff like that.

Every person with Autism has different things that they do well and other things that they have trouble with. For me, like I said, I have a hard time with words, I have a hard time remembering people's names, and sometimes, I may have trouble knowing if someone is joking with me. You may see me walking around by myself – sometimes I pace back and forth when I'm thinking. I also sometimes flap my hands when I get excited or frustrated. So, if you see me doing that, just come over and say "Hey, Rob!" or something like that to me. That usually helps me stop right away. It may look funny, but really everybody does this a little bit. Other people may jump up and down when they are excited or clench up when they get angry. Unfortunately, I flap. But don't worry, I'm OK.

Other than that stuff, I am just like everybody else. I really like movies and music. I go to concerts all the time… the next concert I'm going to is Bruno Mars. By the way, if anyone likes Bruno Mars, let me know – my sister doesn't want to go… so we have a free ticket!

That's really all I have to say. Just remember that you shouldn't judge anyone without getting to know him or her. I'm just a normal kid that happens to have Autism. I don't mind if you don't mind.

Thanks for letting me tell you about myself. Does anyone have any questions?

Robbie

How to tell if your toddler has autism

According to a 2012 National Center for Health Statistics data brief, about half of all children in the United States with an autistic spectrum disorder are diagnosed at age five or older However, many parents are suspicious much sooner. As part of autism awareness month, we bring you clues in toddler development that can alert you to a potential issue. This post follows up on our earlier post "How can I tell if my baby has autism?"

Pediatricians often use a questionnaire called the M-CHAT (Modified Checklist for Autism in Toddlers) as a screening tool. This test can be downloaded for free. In our office we administer the M-CHAT at the 18-month well child visit and again at the two-year well visit, but the test is valid down to 16 months and in kids as old as 30 months. Not every child who fails this test has autism, but the screening helps us to identify which child needs further evaluation.

At 15-18 months of age, children should show the beginnings of pretend play. For example, if you give your child a toy car, the toddler should pretend to drive the car on a road, make appropriate car noises, or maybe even narrate the action: "Up, up, up, down, down, rrrroooom!" Younger babies mouth the car,

spin the wheels, hold it in different positions, or drag a car upside down, but by 18 months, they perceive a car is a car and make it act accordingly. Other examples of pretend play are when a toddler uses an empty spoon and pretends to feed his dad, or takes the T.V. remote and then holds it like a phone and says “hello?” You may also see him take a baby doll, tuck baby into bed, and cover her with a blanket.

Eye contact in American culture is a sign that the child is paying attention and engaged with another person. Lack of eye contact or lack of “checking in” with parents and other caregivers can be a sign of delayed social development.

Kids periodically try to get their parents to pay attention to what they are doing. Lack of enticing a parent into play or lack of interest in what parents or other children are up to by this age is a sign of delayed social development. Ask yourself, “Does my child bring me things? Does he show me things?” Also, although they may not share or take turns, toddlers should still be interested in other children.

Many typical two-year-olds like to line things up. They will line up cars, stuffed animals, shapes from a shape sorter, or books. The difference between a typically-developing two-year-old and one that might have autism is that the **typically-developing child will not line things up the exact same way every time**. It’s fine to hand your child car after car as he contently lines them up, but I worry about the toddler who has a tantrum if you switch the blue for the green car in the lineup.

Two-year-olds should speak in 2-3 word sentences or phrases that communicate their needs. Autism is a communication disorder, and since speech is the primary means to communicate, **delayed speech may signal autism.** Even children with hearing issues who are speech-delayed should still use vocal utterances and gestures or formal sign language to communicate.

Atypically terrible "terrible twos." Having a sensory threshold above or below what you expect may be a sign of autism. While an over-tired toddler is prone to meltdowns and screaming, parents can often tell what triggered the meltdown. For example, my oldest, at this age, used to have a tantrum every time the butter melted on his still-warm waffle. Yes, it seemed a ridiculous reason to scream, but I could still follow his logic. Autistic children are prone to screaming rages beyond what seems reasonable or logical. Look also for the child who does not startle at loud noises, or withdraws from physical contact because it is overstimulating.

By three years, children make friends with children their own age. They are past the "mine" phase and enjoy playing, negotiating, competing, and sharing with other three-year-olds. Not every three year old has to be a social butterfly but he should have at least one "best buddy."

Regression of skills at any age is a great concern. Parents should alert their child's pediatrician if their child stops talking, stops communicating, or stops interacting normally with family or friends.

It' s okay to compare. Comparing your child to other same-age children may alert you to delays. For example, I had parents of twins raise concerns because one twin developed communication skills at a different pace than the other twin.

Although you may wonder if your child has autism, there are other diagnoses to consider. For instance, children need all of their senses intact in order to communicate well. I had a patient who seemed quite delayed, and it turned out that his vision was terrible. He never complained about not seeing well because he didn't know any other way of seeing. After my patient was fitted with strong glasses at the age of three, his development accelerated dramatically. The same occurs for children with hearing loss—you can't learn to talk if you can't hear the sounds that you need to mimic, and you can't

react properly to others if you can’t hear them.

If you or your pediatrician suspect your child has autism, early, intensive special instruction, even before a diagnosis is finalized, is important. Every state in the United States has Early Intervention services that are parent-prompted and free for kids. The sooner your child starts to works on alternate means of communication, the quicker the frustration in families dissipates and the more likely your child is to ultimately develop language and social skills. Do not be afraid of looking for a diagnosis. He will be the same child you love regardless of a diagnosis. The only difference is that he will receive the interventions he needs.

Julie Kardos, MD and Naline Lai, MD

How can I tell if my baby has autism?

April is National Autism Awareness month in the United States. Early recognition improves outcome. This April we will post a series on the recognition of autism in a baby and in a toddler, as well as a personal story. – Drs. Kardos and Lai

Home videos of children diagnosed with autism reveal that even before their first birthdays, many autistic children demonstrate abnormal social development that went unrecognized.

Autism is a communication disorder where children have difficulty relating to other people. Pediatricians watch for speech delay as a sign of autism. Even before your child is expected to start talking, around a year old, you can watch for communication milestones. Problems attaining these milestones may indicate autism or other disorders such as hearing loss, vision loss, isolated language delay, or other developmental delays:

By six weeks of age, your baby should smile IN RESPONSE TO YOUR SMILE. This is not the phantom smile that you see as your baby is falling asleep or that gets attributed to gas. I mean, your baby should see you smile and smile back at your smile. Be aware that babies at this age will also smile at inanimate

objects such as ceiling fans, and this is normal for young babies to do.

By 2 months of age, babies not only smile but also coo, meaning they produce vowel sounds such as “oooh” or “aaah” or “OH.” If your baby does not smile at you by their two month well baby check up visit or does not coo, discuss this delay with your child’s health care provider.

By four months of age, your baby should not only smile in response to you but also should be laughing or giggling OUT LOUD. Cooing also sounds more expressive (voice rises and falls or changes in pitch) as if your child is asking a question or exclaiming something. Most babies this age smile and coo at anyone who smiles at them- shyness typically is not seen yet.

Six-month-old babies make more noise, adding consonant sounds to say things like “Da” and “ma” or “ba.” They are even more expressive and seek out interactions with their parents. Parents should feel as if they are having “conversations” with their babies at this age: baby makes noise, parents mimic back the sound that their child just made, then baby mimics back the sound, like a back and forth conversation.

All nine-month-olds should know their name. Meaning, parents should see their baby responding to their name being called. Baby-babble at this age, while it may not include actual words yet, should sound very much like the language that they are exposed to primarily, with intonation (varying voice pitch) as well. Babies at this age should also do things to see “what happens.” For example, they drop food off their high chairs and watch it fall, they bang toys together, shake toys, taste them, etc.

Babies at this age look toward their parents in new situations to see if things are ok. When I examine a nine month old in my office, I watch as the baby seeks out his parent as if to say,

“Is it okay that this woman I don’t remember is touching me?” They follow as parents walk away from them, and they are delighted to be reunited. Peek-a-boo elicits loud laughter at this age. Be aware that at this age babies do flap their arms when excited or bang their heads with their hands or against the side of the crib when tired or upset. These “autistic-like” behaviors are normal at this age.

By one year of age, children should be pointing at things that interest them. This very important social milestone shows that a child understands an abstract concept (I look beyond my finger to the object farther away) and also that the child is seeking social interaction (“Look at what I see/want, Mom!”). Many children will have at least one word that they use reliably at this age or will be able to answer questions such as “what does the dog say?” (child makes a dog sound).

Even if they have no clear words, by their first birthday children should be vocalizing that they want something. Picture a child pointing to his cup that is on the kitchen counter and saying “AAH AAH!” and the parent correctly interpreting that her child wants his cup. Kids at this age also will find something, hold it up to show a parent or even give it to the parent, then take it back. Again, this demonstrates that a child is seeking out social interactions. Autistic children typically do not seek this out.

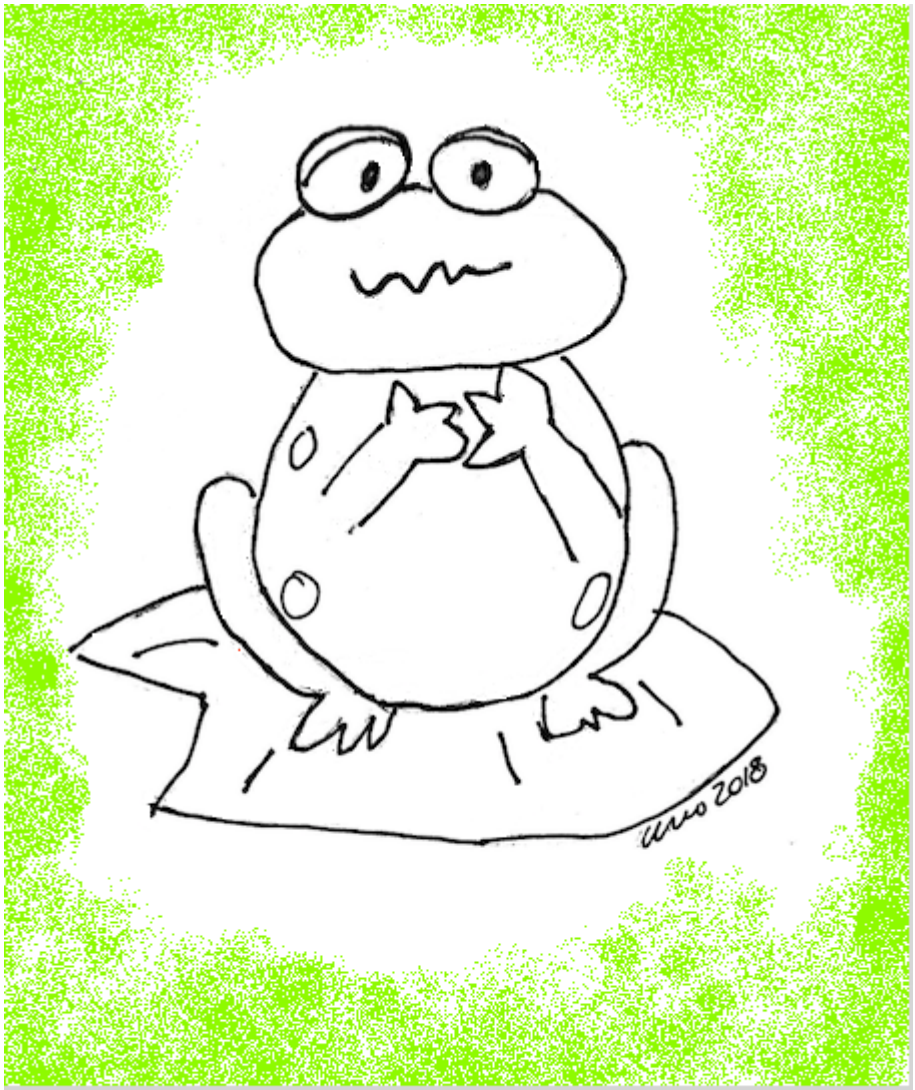
Know that it is normal that at this age children have temper tantrums in response to seemingly small triggers such as being told “no.” Difficulties with “anger management” are normal at age one year.

Our next post will show signs of autism in toddlers.

For more information, check out the Centers for Disease Control site.

Julie Kardos, MD and Naline Lai, MD

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.

Julie Kardos, MD and Naline Lai, MD

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.

Julie Kardos, MD and Naline Lai, MD

Kids are vaping: e-cigarettes

It’s time for another Two Peds in a Pod photo quiz.

The question: What’s depicted in this photo?

If you answered: a pen, a thumb nail drive, or an asthma inhaler, you would be wrong.

Kids use these devices, which purposely look like common innocuous objects, to inhale electronic cigarettes (e-cigarettes). Vaping, also called “Juuling” and an even more concentrated form of vaping, called “dripping,” is unfortunately popular among teens. It’s unhealthy: the stuff that the kids are inhaling contains nicotine and other chemicals.

Ask your middle schooler or high schooler. They most likely have seen these devices if they have not actually used one.

Parents need to know kids are vaping in school as well as outside of school. Unlike conventional cigarettes, it’s easy for the kids to hide: no smoky smell, no cigarette cartons. The vaping liquid or “e-juice” comes in all kinds of “kid friendly” flavors such as gummy bear, fruit, or chocolate, and the devices needed to inhale them look like items in every kid’s pencil case or backpack.

It’s easy for kids to get the e-juice on the internet because online stores don’t always ask for proof of age (legal age to buy is 18 years in the US). Most e-juices contain nicotine, which is addictive. Emerging data show that kids who vape are more likely to go on to use regular cigarettes than kids who do not vape.

Bottom line: Vaping, or using electronic cigarettes, is unhealthy and addictive, and startlingly easy for kids to hide.

Julie Kardos, MD and Naline Lai, MD