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.

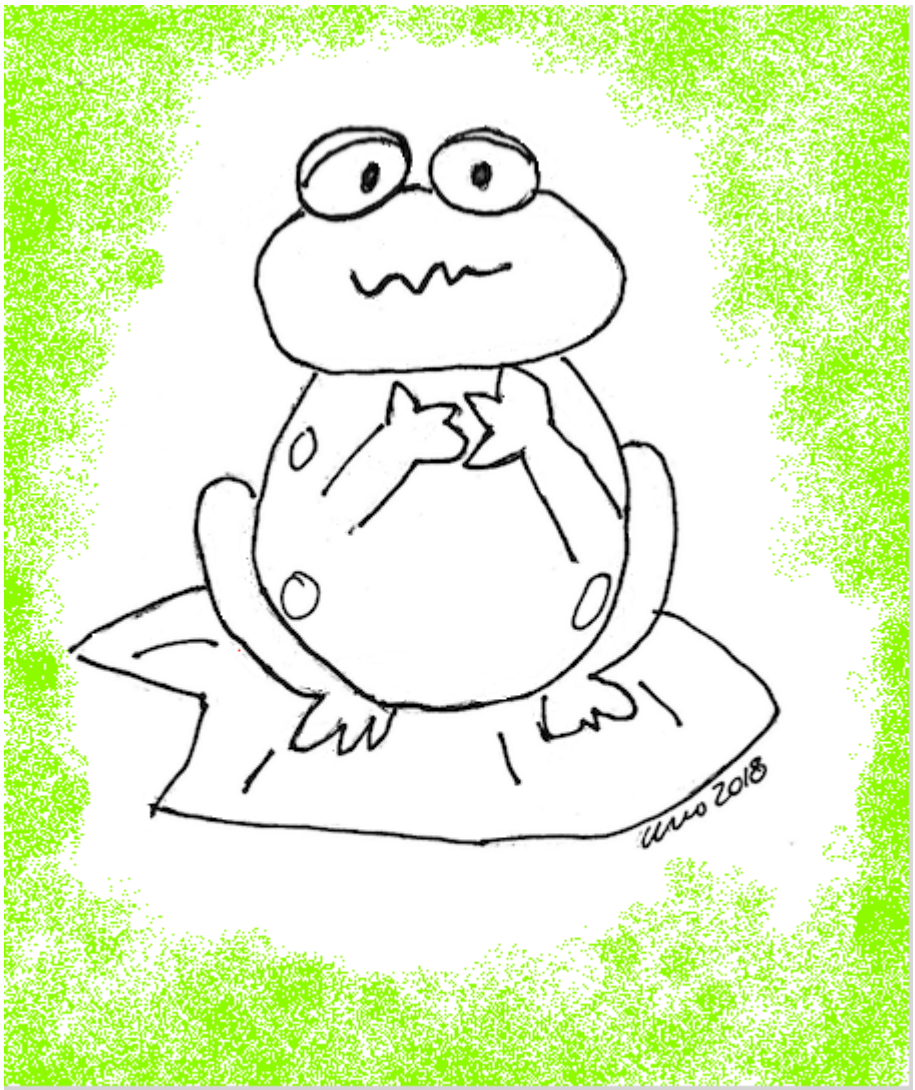
Know that it is normal that at this age children have temper tantrums in response to seemingly small triggers such as being told “no.” Difficulties with “anger management” are normal at age one year.

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

Worry wart: how to treat a wart

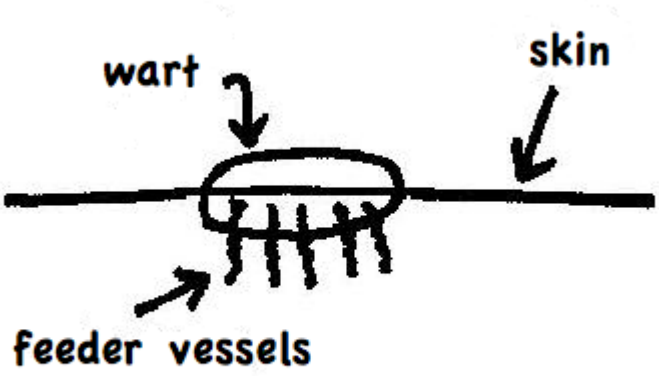
Nope, warthogs don’t actually have warts. But kids often do!

Emma’s dad and I both peered at the filamentous growth dangling from his nine year old’s right nostril. “Yes,” I said, “it’s definitely a wart.”

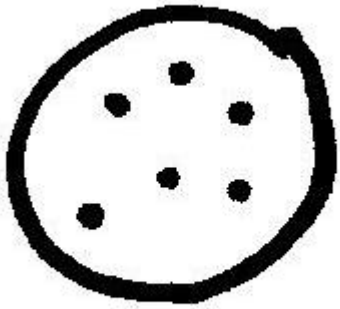
Emma’s dad offered, “When I was a kid, I heard the way to get rid of a wart was to cut a potato in half, rub it on the wart, and bury the potato in the backyard. Legend had it, by the time the potato disintegrates, the wart will be gone.”

“I wish it were so easy,” I replied.

Warts are caused by skin-dwelling viruses. On the feet, warts can sometimes be mistaken for calluses. One distinguishing feature is that warts sit in the skin like this:



Fine “feeder” blood vessels extend from the wart into the skin. Therefore, if you scrape off the top layer of a wart, a dotted pattern usually appears from above. The dots will not appear in a callus. View from above:



There are simply no glamorous ways to get rid of warts. Most treatment modalities destroy warts by pulverizing the home they live in, a.k.a. your skin. Your doctor may be armed with various agents such as liquid nitrogen or dimethyl ether propane, which produces a chemical “freeze” and dries up the wart. Another agent called cantharidin (otherwise known as “beetle juice”) is a caustic liquid derived from the blister beetle. Application of beetle juice causes the warts to blister.

Some doctors will even manually take a scalpel and cut out the

warts.

Like I said, there are no glamorous treatments. However, more gentle creams which stimulate the immune system, such as Imiquimod (Aldara) show some promise in children. Other compounds such as 5-fluorouracil can be topically applied or injected and treatments such as pulsed dye laser therapy have mixed reviews.

Over-the-counter remedies exist in a milder form. Commonly used wart removers such as Compound W, Dr Scholl's Clear Away Wart, and Duofilm all contain salicylic acid. The acid slowly dries up the warts. When applying salicylic acid, after a few applications make sure you peel the dead crusty top layer off the wart. Without peeling, future medicine will not reach the wart. These methods can take weeks to months to work, but they do work.

And don't forget the duct tape. Duct tape, the great all-purpose household item, has also been shown to speed up the resolution of warts. Scientists hypothesize the constant presence of the adhesive somehow stimulates a natural immune response. If you try duct tape, have your child wear the duct tape over the wart for several days in a row and then give a day off. If the wart is on a hand or foot, the tape tends to fall off during the day: just re-apply some tape at bedtime. Effects should be seen within a couple of months if not sooner. Now, the original study that showed duct tape was helpful, was followed by a study which showed duct tape was not helpful. Some hypothesize that the results differ because silver sticky duct tape was used in the initial study, while the later study used less sticky duct tape. So be sure to use the old-fashioned silver duct tape.

The prevention of warts is tricky. Some people just seem genetically predisposed. However, your best bet for keeping warts away is to keep your child's skin as healthy as possible. Warts tend to gravitate towards areas of skin

broken down by friction such as feet or fingers. Liberally apply moisturizing creams daily to prone areas. After a summer of wearing flip-flops and walking on the rough cement by the side of a swimming pool in bare feet, many children end up with warts on the bottom of their feet. I know a teen whose warts on the tips of her fingers stemmed from months of guitar strumming.

Turns out that even without treatment, 60% percent or more of all warts will disappear spontaneously within two years.

Coincidentally, I think that’s also the time it takes for a potato half to disintegrate.

Naline Lai , MD and Julie Kardos, MD

“Ya Gotta Have Heart!” Heart Murmurs Explained

Conversation hearts murmuring

When the Tin Man was a child in Oz, I'm sure his pediatrician never told his parents, "Has anyone ever said your child has a heart murmur? I hear one today."

I know that when I tell parents about a heart murmur in their child, their hearts skip and jump. But not all heart murmurs are bad.

What is a heart murmur?

A heart murmur is an extra sound that we pediatricians hear when we listen to a child's heart with a stethoscope. A normal heart beat sounds like this: "lub, dub. lub, dub. lub, dub." A heart murmur adds a whooshing sound. So what we hear instead is "lub, *whoosh*, dub" or "lub, dub, *whoosh*."

The “whoosh” is usually caused by blood flowing through a relatively narrow opening somewhere in or around the heart. Think of your blood vessels and heart like a garden hose. If you run the water (blood) very hard, or put a kink or cut a hole in the hose, the whoosh of the water grows louder in those locations.

Heart murmurs signal different issues at different ages.

In a newborn, some types of heart murmurs are expected. Normal newborn hearts contain extra holes that close up after the first hours or days of birth. One type of murmur occurs as the infant draws in his first breath and holes in the heart, present inside the womb, begin to seal. As the holes get narrower, we sometimes hear the “whoosh” of blood as it flows through the narrowing opening. Then these holes close completely and the murmur goes away.

However, some murmurs in infancy signal “extra holes” in the heart. As pediatricians, we experience our own heart palpitations when moms want to leave the hospital early with their infants who are less than 48 hours old. We worry because many infants who have abnormal hearts may not develop their abnormal heart murmurs and other signs of heart failure until the day or two after birth.

Preschool and early school-age children often develop “innocent” heart murmurs. “Innocent” implies that extra blood flows through their hearts, but the hearts are structurally normal. These murmurs are fairly common and can run in families. However, there are some significant heart problems which do not surface until this age. For this reason, remember to schedule those yearly well child checkups.

For teens, during the pre-participation sports physical, pediatricians listen carefully for a murmur that may indicate that an over grown heart muscle has developed.

What else can cause a heart murmur?

Holes are not the only culprit behind a murmur. The whoosh sound can also arise when a person is anemic and blood flows faster than normal. In anemic kids, the blood flows faster because it lacks enough oxygen-carrying red blood cells and the heart needs to move blood faster in order to supply oxygen to the body. The most common cause for anemia is a lack of eating enough iron-containing foods. Subsequently, we hear these flow murmurs in children whose diets lack iron, in teenagers who grow rapidly and quickly use up their iron stores, and in girls who bleed too much at each period. Replenishing the iron level makes a heart murmur from anemia go away.

Even a simple fever can cause a heart murmur on physical exam. The murmur goes away when the fever goes away.

Pediatric health care providers can often distinguish between “innocent” heart murmurs and not-so- innocent heart murmurs by the sound of the murmur itself (not all “whooshes” sound alike). If any question exists, your child will be referred for more testing, which could include a chest x-ray, an EKG (electrocardiogram), an ECHO (echocardiogram, or ultrasound of the heart), or evaluation by a pediatric cardiologist.

If your child’s pediatrician tells you that your child has a heart murmur, “take heart.”

Many times a murmur comes and goes or just becomes part of your child’s baseline physical exam. Even if your child has a serious heart problem, most cases respond well to medication, surgery, or both. While not all heart problems cause heart murmurs, and while not all murmurs signal heart problems, the presence of a heart murmur in a child can signal that your child needs further testing.

Unless, of course, your child is the Tin Man. In this case, extra sounds indicate that your child needs more oil!

Julie Kardos, MD and Naline Lai, MD

Raising emotionally healthy boys

photo by Lexi Logan, www.lexilogan.com

The recent Parkland shooting in Florida is causing many to wonder how to support the emotional health of boys in their families and communities. We welcome therapist Dina Ricciardo's words of wisdom— Drs. Kardos and Lai

Your son is crying. A mad dash across the playground has led to a spectacular trip and fall, complete with a bloody knee and hands full of dirt. Part of you wants to hold him on your lap and console him until he stops crying. The other part of you wants to firmly wipe away his tears and tell him to be brave. Which part of you is right?

In a world where there is a great deal of emphasis placed on the emotional health of girls, our boys are frequently overlooked. While girls are typically encouraged to develop and express a broad range of emotions, boys are socialized from a young age to suppress their feelings. As a result, many boys and men struggle to express fear or sadness and are unable to ask for help. It is time for us adults to stop perpetuating stereotypes and myths about manhood, and help each other raise emotionally healthy boys. Here are five ways for us to do so:

Make his living environment a safe space to express emotions. Give your son permission to express *all* of his feelings. Boys typically do not have the freedom to show the full range of their emotions in school and out in the world, so it is essential that they have that freedom at home. Nothing should be off limits, as long as feelings are expressed in a manner that is not destructive.

Expose him to positive male role models. Boys need to be exposed to positive male figures who can to indoctrinate them into their culture and teach them how to be men. It is an important rite of passage in a boy's development. Take a look around your social ecosystem and ask yourself, "Who would be good for my son?" Other parents, coaches, teachers, and pastors are examples of individuals who can play a positive role in his life.

Understand your unique role. Each parent plays a unique role in the development of a son, and that role changes over time. A mother is a son's first teacher about love and what it looks

like, and this dynamic can breed a particular kind of closeness. As a boy grows and begins to develop his sexuality, however, it is natural for him to pull away a bit from his mother and turn more towards his father for guidance. While this distance can be unsettling for mom, it marks a new phase in a son's relationship with his father, who typically provides a sense of security and authority in a family as well as support for a boy's developing identity. Mothers still play an important role, but that role may look different. As parents, it is important to re-evaluate what our sons need from us at each stage of their development.

Look at the world with a critical eye. Our culture not only glorifies violence, it equates vulnerability in males with weakness and attempts to crush it. That does not mean we have to accept this paradigm. Talk honestly with your son about how and when to be gentle and compassionate, educate him on how the world view softness in men, and never tolerate anyone shaming him when he exhibits these traits. There is no shame in showing vulnerability, it is actually an act of courage.

Take a look in the mirror. Whether you are a mother or a father (or both), be honest with yourself: what are your beliefs about manhood? Do you feel safe expressing all of your feelings, or are some of them off-limits? If you are perpetuating negative stereotypes about men or are not comfortable with a full range of emotions, then your son will follow in your footsteps. Regardless of our own gender, we cannot expect our children to be comfortable with their feelings if we are not comfortable with our own.

There are times when insuring the emotional health of your son will feel like an uphill battle. Keep the conversation open, and do not be afraid to talk with others about the dilemmas of boyhood and manhood. And if you are looking for an answer to the playground dilemma, then I will tell you that both parts of you are right. Sometimes our sons need loving compassion, and sometimes they need a firm nudge over the hump. You know

your child better than anyone else, so it is up to you to decide which approach to use and when.

Dina Ricciardi, LSW, ACSW

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.

When a pet dies

Photo by Lexi Logan

We welcome Bereavement Counselor Amy Keiper-Shaw who shares with us how to discuss the death of a pet with your child.
–Drs. Lai and Kardos

When I first graduated from college I worked as a nanny. One day the mom shared with me that their family goldfish recently died. As this was her daughter's first experience with death, we schemed for nearly 20 minutes to find the best way to talk to her child. The mom and I thought it could be an excellent teaching moment.

We pulled the girl away from her playing to explain that the fish had died. We told the girl we'd help her have a funeral if she wanted, and we would find a box (casket) to bury the fish so she could say her goodbyes. We explained what a casket

was and what a funeral was in minute detail. After our monologue we stopped, we asked if she had any questions.

After a slight pause she asked, “Can’t we just flush it?”

The lesson I learned from that experience, and still use to this day, is to keep things simple, and know my audience. Sometimes as parents we overcompensate for our own fears and make situations more challenging than they need to be.

Here are some tips on how to talk to your children about pet loss:

Tell your child about the death, and then pause. Ask her what she thinks death means before moving on with further explanations. This will help you know if she has questions or if she has enough information for the moment. Children often need a small amount of information initially and will later come back to you several times later to ask more questions after they process the information.

Remember to express your own grief, and reassure your child that many different feelings are ok. Be sure to allow children to express their feelings. If your child is too young to express herself verbally, give her crayons and paper or modeling clay too help express grief.

Avoid using clichés such as: Fluffy “went to sleep.” Children may develop fears of going to bed and waking up. The phrase “God has taken” the pet could create conflicts in a child and she may become angry at a higher power for making the pet sick, die, or for “taking” the pet from them.

Be honest. Hiding a death from a child can cause increased anxiety. Children are intuitive and can sense is something is wrong. When the death isn’t explained they make up their own explanation of the truth, and this is often much worse than the reality of what occurred.
Children are capable of understanding that life must end for

all living things. Support their grief by acknowledging their pain. The death of a pet can be an opportunity for a child to learn that adult caretakers can be relied upon to extend comfort and reassurance through honest communication.

Developmental Understanding of Death

Two and three-year-olds
Often consider death as sleeping, therefore tell them the pet has **died** and will not return.

Reassure children that the pet's failure to return is unrelated to anything the child may have said or done (magical thinking).

A child at this age will readily accept another pet in the place of a loved one that died.

Four, five, and six-year-olds
These children have some understanding of death but also a hope for continued living (a pet may continue to eat, play & breathe although deceased).

They can feel that any anger that they had towards the pet may make them responsible for the pet's death ("I hated feeding him everyday").

Some children may fear that death is contagious and could begin to fear their own death or worry about the safety of their parents.

Parents may see temporary changes in their child's bladder/bowels, eating, and sleeping.

Several brief discussions about the death are more productive than one or two prolonged discussions.

Seven, eight, and nine-year-olds
These children have an understanding that death is real and irreversible.

Although, to a lesser degree than a four, five, or six-year-old, these children may still possibly fear their own death or the death of their parents.

May ask about death and its implications (Will we be able to get another pet?).

Expressions of grief may include: somatic concerns, learning challenges, aggression, and antisocial behavior. Expression may take place weeks or months after the loss.

Adolescents
Reactions are similar to an adult's reaction.

May experience denial which can take the form of lack of emotional display so they could be experiencing the grief without outwards manifestations.

Resources:
Petloss.com– a gentle and compassionate website for pet lovers who are grieving the death or an illness of a pet- they have a Pet Loss Candle Ceremony every week

Your local veterinarian- often your veterinarian has or knows of a local pet loss group

Handsholdinghearts.org– our group of counselors offer grief support to children, teens, and their families centered in Bucks County Pennsylvania.

Books on pet loss for children:

Badger's Parting Gifts (children) by Susan Varley
Lifetimes by Brian Mellonie & Robert Ingpen
The Tenth Good Thing About Barney (children) by Judith Viorst

Amy Keiper-Shaw, LCSW, QCSW, GC-C

Amy Keiper-Shaw is a licensed grief counselor who holds a Masters Degree in clinical social work from the University of

Pennsylvania. For over a decade she has served as a bereavement counselor to a hospice program and facilitates a bereavement camp for children. She directs Handsholdinghearts, a resource for children who have experienced a significant death in their lives.