Ear wax in your child: what to do with the goo

Babies are gooey. Spew tends to dribble out of every orifice and the ear is no exception.

Devin's mother tipped her four month old baby's head sideways in the office the other day and asked me what to do about the oily, yellow wax smeared around the opening of his ear canal. Despite the copious amount of wax on the outside, Devin's ear canals were clear. "But the wax is simply disgusting," said Devin's mom, "Can I clean his ears? "

If you can get the wax with a wash cloth, it's fair game. Otherwise, leave it alone. It doesn't matter if you use a wash cloth or cotton swab. The special shaped cotton swabs with the safety tips are unnecessary. Rest assured, you will not go too deeply into the ear canal if you only scrape off what is visible.

Now suppose your pediatrician does say the wax should be removed. Place an over-the-counter solution such as Debrox in the ears (children and adults can use the same formulation) – three to four drops one or two times a day (during sleep is easiest for babies and toddlers) for a few days. The solution

softens wax. For maintenance, mineral oil and olive oil are favorite remedies. Place one drop daily in ears. In the office some pediatricians can use a water irrigation system (like a water squirter in your ear) to wash out the wax. The worst side effect is that the child's shirt sometimes gets wet. Irrigation is a very effective for removing wax in a school-aged or teenaged child who complains of difficulty hearing.

Some say wax evolved to help keep bugs and other debris from reaching deep into our ear canals. Case in point: one of my least favorite memories during residency is of picking out pieces of a cockroach entrapped in a child's earwax!

Keep in mind the amount of wax you see on the outside of the ear is not indicative of the actual amount inside the ear canal. Chances are, the wax is not hard and does not block the ear drum. Even if there is a large amount of wax, it is unlikely to greatly affect a baby's hearing unless the wax is stuck against the ear drum. Equally normal is that some babies and children don't seem to produce any ear wax. If you are concerned about your child's ear wax or about her hearing, have your pediatrician take a peek with a light.

If you find you are constantly cleaning your kid's waxy ears, take heart. At least there won't be any roaches "bugging" them.

Naline Lai, MD and Julie Kardos, MD

PS: Medical vocabulary FYI: light used to look into ears= otoscope. Medical term for ear wax= cerumen.

We give thanks, 2016

Nearly seven years ago, on the swimming pool bleachers at the local Y, I happened to sit next to Lexi Logan. Above the echoing din of kids splashing, I discovered that although she was trained as a painter, Lexi was interested in branching out into photography. Coincidentally, Dr Kardos and I were interested in branching medicine out into a new media called the internet and were dismayed at the lack of publicly available photos to accompany our blog posts. Lexi and I intersected in the right place at the right time. Since that chance meeting, Lexi has generosity shared dozens of photos with Two Peds in a Pod.

The woman in the photo below, between your Two Peds (Dr. Kardos with the curly hair, Dr. Lai with the straight hair), is our photographer extraordinaire, Lexi Logan. Her work, which you can check out at www.lexilogan.com, speaks for itself. Local peeps may want to contact her to take their own family photos.

This Thanksgiving we say thanks to all those parents we've ever sat next to on bleachers. All the kid-related information we have learned, from navigating chorus uniforms, bus stop times, best teachers, fun summer camps, and even starting up blogs, has been invaluable.

In particular- thank you, Lexi!

We wish all of our readers a very healthy and happy Thanksgiving,

Dr. Naline Lai with Dr. Julie Kardos

Extra school services offered to your child? Just say yes!

When I was in first and second grade, I took “special gym.”

I attended a public school in a small New Jersey town. The school building was about 100 years old, and the “special services” that my school offered were speech, reading help, and special gym.

I remember being THRILLED that I was selected to take special gym, because instead of just *one* day a week of bouncing balls and running races and turning somersaults during the school day, I got to go *twice* a week. I remember how upbeat and energetic the gym teacher was, and how much fun she made these exercises. I do not recall such words as “physical therapy” or “occupational therapy.” In fact, I did not realize the true point of the extra gym days until many years later, when I was in college and reminiscing about elementary school and caught myself mid-sentence:

“Well, when I was in first grade, I took special gym… hey… WAIT a MINUTE….!”

That’s when I realized that I had been flagged with a coordination challenge. Unbeknownst to me, in school I went to

physical therapy weekly.

Now that first-quarter parent teacher conferences are over, you may be surprised that your child has been offered special services by the school. Teachers spend hours a day with our kids and are experts in the age group that they teach. Not all kids are good at learning all subjects and not all are equally sociable or equally physically adept. When teachers ask a parent's permission to supply extra help, parents should not take this request as an affront or attack on their parenting. Rather, it is an opportunity to help kids succeed.

I was never suspicious about my inclusion in special gym. No one made fun of me for being in the class, and in fact many were jealous. Kids in early grades may be aware that some of their classmates come and go during the day, but they do not distinguish between kids pulled out for a gifted program from kids pulled out for remedial education. As an adult, I appreciate that my teachers made me feel good about being included in the special gym club.

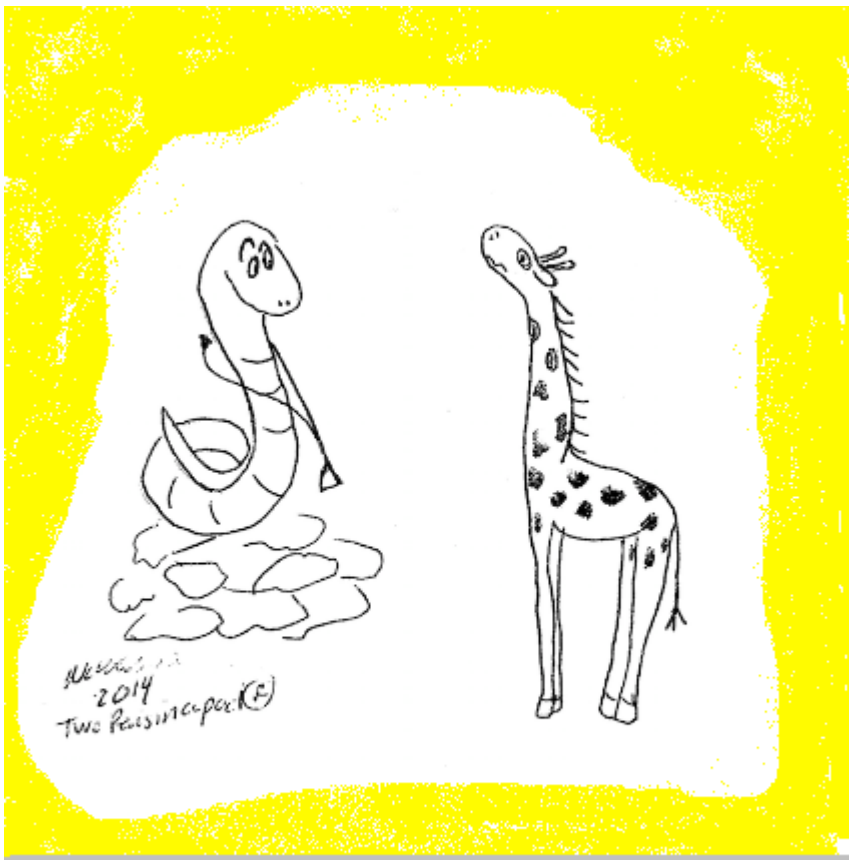
I have a magnet on my car now that says, simply, "13.1," which is the number of miles that I ran to complete the Trenton Half-Marathon this past October. Special gym did not hold me back—it propelled me forward. I had no idea that my participation in special gym was emotionally charged for my mom until after I called my dad to tell him my race time (2 hours, 11.5 minutes). Only then did he tell me how crushed my mom had been about my inclusion in special gym. I am grateful that she hid that from me.

My message: Let your kids get extra help in school, allow them to be pulled out of a class they are failing and placed into an environment where they can learn and overcome challenges. Allow yourself to mourn the loss of the child you may have pictured. But know this: young children do not have enough life experience to independently think of themselves as failures in the early school years. They look to adults who

are important to them for how to respond to challenges and frustration. Encourage them with the positive message that they will receive extra attention and extra time to work at reading or math or physical skills or speech skills. Who knows? They may become the kid who applies to medical school or runs a marathon (or a half-marathon) someday.

Julie Kardos, MD

Sore throat relief



The giraffe always felt his sore throat lasted longer than everyone else's sore throat.

Many times parents bring their children with a sore throat

to our office to “check if it’s strep.” Some are disappointed to find out that their child does NOT have strep. Moms and Dads lament, “But what can I do for him if he can’t have an antibiotic? At least strep is treatable.”

Take heart. Strep or no strep, there are many **ways to soothe your child’s sore throat**:

- **Give pain medication** such as acetaminophen (brand name Tylenol) or ibuprofen (brand names Advil or Motrin). Do not withhold pain medicine before you bring her in to see her pediatrician. Too many times we hear parents say, “We wanted you to see how much pain she is in.” No need for this! Pediatricians are all in favor of treating pain as quickly and effectively as possible. Pain medicine will not interfere with physical exam findings nor will it interfere with strep test results.
- **Give lots to drink**. Some kids prefer very cold beverages, others like warm tea or milk. Avoid citrus juices since they sometimes sting sore throats. Frozen Slurpies or milkshakes, on the other hand, feel great on sore throats. Tell your child that the first three sips of a very cold drink may hurt, but then the liquid will start to soothe the throat. Watch for signs of dehydration including dry lips and mouth, no tears on crying, urination less than every six hours, and lethargy.
- **Provide soft foods** if your child is hungry. For example, noodles feel better than a hamburger on a sore throat. And ice-cream or sherbet therapy is effective as well.
- **Try honey** (if your child is older than one year) – one to two teaspoons three times a day. Not only can it soothe a sore throat but also it might quiet the cough that often accompanies a sore throat virus. Give it alone or mix it into milk or tea.
- **Kids older than three years** who don’t choke easily can suck on lozenges containing pectin or menthol for relief. Warning: kids sucking on lozenges may dupe

themselves into thinking they are hydrating themselves. They still need to drink to stay hydrated.

- **Salt water gargles** are an age-old remedy. Mix 1 teaspoon of salt in 6 ounces of warm water and have your kid gargle three times a day.
- **Magic mouthwash**: For those older than 2 years of age, mix 1/2 teaspoon of liquid diphenhydramine (brand name Benadryl 12.5mg/5ml) with 1/2 teaspoon of Maalox Advanced Regular Strength Liquid (ingredients: aluminum hydroxide, magnesium hydroxide 200 mg, and simethicone) and give a couple time a day to coat the back fo the throat prior to meals. The Maalox coats the throat and the benedryl acts as a weak topical anesthetic (pain reliever). **Do not** use the Maalox formulation which contains bismuth subsalicylate because bismuth subsalicylate is an aspirin derivative, and aspirin is linked to Reye's syndrome.
- For kids three years and older, **try throat sprays** containing phenol (brand name Baker's P&S and Chloraseptic® Spray for Kids). Use as directed.

Strep throat typically does **not** cause a bad cough, profuse runny nose, ulcers in the throat, or laryngitis. If your child has these other symptoms in addition to her sore throat, you can be fairly sure that she does NOT have strep. For a better understanding of strep throat, see our updated post on this topic.

The following are each a very important sign that a child with a **sore throat needs to see a doctor** for further evaluation:

1-can't swallow (kids might even spit out their own saliva)

2-can't open his mouth fully

3- hurts so much that the pain is not alleviated with the above measures in this post

4- presence of fever 101F or higher for more than 3-4 days

5-is accompanied by a new rash

Please also see our prior post on how to tell if you need to call your child's doctor for illness.

_Julie Kardos, MD and Naline Lai, MD

Stop a bully: talk, walk, squawk, and support

photo by Lexi Logan

Can you identify your child in any of these scenarios?

-Your second grader comes off the school bus crying because another student was teasing him the entire ride home about his new glasses.
-Your fifth grader was punched on the school yard by a sixth grader and none of the playground teachers saw it happen. Your child's friend shoved the older child off your child before more damage was done.
-Your ninth grader keeps missing the school bus so you have to drive her to school. When she comes home from school she uses the bathroom immediately. You find out she avoids the bus and the school bathroom because kids make fun of her in both places.

Whatever your child's age, when you realize he or she is being bullied you will be outraged. In fact you might be tempted to retaliate against the bully yourself. However, here are more appropriate ways to help your child.

Bullying should never be tolerated. Teach your child how to directly deal with a bully, but be quick to talk also to the adult supervising your child when the bullying occurs. Your child should always feel safe in school, day camp, on a sports team, or any other adult-supervised activity.

Bullies are always in a position of power over their victims; either they are physically larger, older, or more socially popular. Teach your child first to try a strong verbal response (**talk**) such as "STOP talking to me that way!" or "Don't DO that to me!" Speaking strongly and looking the bully in the eye may take away some of the bully's power as well as attract attention of nearby peers or adults who can help your child.

Teach your child to **walk** away from a fight. Tell him to keep on walking toward a teacher, a classroom, a peer, or anyone else who can offer safety from a bully. Train him to breathe deeply/ignore/de-escalate situations to diffuse a bully's anger.

Have your child tell a teacher, camp counselor, coach, or other supervising adult about the abuse (**squawk**) as soon as it occurs. Always encourage your children to talk to you as well. Remember at home to ask your child questions such as "How is school," "How are your friends," "Do you know any kids who are being bullied?," and "Are YOU being bullied?" Dr. Lai always advises her patients to tell as many different adults as possible if he is not feeling safe. Even if one adult is unsure of how to help, sooner or later some one will.

If your child says he is angry at a friend or a classmate, be sure to ask questions that encourage your child to elaborate, such as "Oh, what happened?" or "Did something happen between you?" Listen carefully to his response. He may be taking out his anger at a bully on his own friends. This response is in retaliation for his friend's failure to protect him from a bully. Also, is your child becoming more reluctant to attend school, "missing" the bus more often and thus requiring a ride, or acting angry or sad more often? Kids who are victims of bullying can act like this.

In school, once you are aware that your child is a victim, talk not only to your child about how she should handle a bully but also alert your child's teacher and/or school principal about the situation (**support**). You should tell them in your child's words what happened, what was said, and be clear that you are asking for more supervision so that the bully has less access to your child. Ask for more supervision during times when there is usually less adult presence such as in the lunchroom or on the schoolyard. Your school may already have a "no bullying" policy. Often, the aggressor gets the heavier consequence in the event of a conflict. Again, children have a right to feel safe in school.

Restore your child's self-confidence. Bullies pick on kids who are smaller and weaker than they are, physically as well as psychologically. So your child has more positive experiences with kids who do <u>not</u> bully, encourage your child to invite

friends over to your home or host a fun group activity (kickball game in your backyard, show a movie/supply popcorn, etc.). Do family activities and show your child that you enjoy spending time with him. Enroll your child in activities that increase his self esteem such as karate, sports, or music lessons. A child who feels good about himself “walks taller” and is less likely to attract a bully

As a parent, you might read this post and think, “Yes, but I’d rather just teach my child to take revenge.” Unfortunately, escalating the situation only breeds anger and in fact may get your child into trouble. Rather than “hate” the bully, help your child see that a bully deep down feels insecure. A bully resorts to making himself feel better by making others feel bad. Teach your child to pity the bully. With your guidance, your child will project self-confidence and a bully will never, ever, be able to touch him.

While the topic of cyper-bullying could occupy an entire separate post, we just want to alert you to the power that social media has over our kids as well. Ask your kids and teens directly about bullying that occurs on-line just as you would ask about bullying at school. Virtual bullying, unfortunately, is just as potentially harmful as in-person bulling, and is a known risk factor for teen suicide. Remind your children how important it is to refrain from revenge: better to disengage from social media than to respond to on-line bullying because your child will leave a permanent footprint on their on-line presence. Lay down the general rule of never posting anything negative (even a simple “dislike”) online.

Help your child talk, walk, squawk and seek support. All kids deserve to feel secure in themselves and in the world around them.

Additional resources:

The American Academy of Pediatrics

Stopbullying.gov–Bully prevention site managed by U.S. Department of Health and Human Services

Cyberbullying Research Center–an organization dedicating to providing up to date information on cyberbullying

Teaching tolerance– a site where parents and educators can learn ways to foster tolerance

Julie Kardos, MD and Naline Lai, MD

How to raise an optimist (even in an election year)

In this time of United States "election stress," we bring back guest bloggers psychologist Dr. Gage and pediatrician Dr. Penaflor's post on how to build optimism in your children.

Recently, my daughter's friend announced before a race, "I'm just not going to try my best."

Why would a child give up before even starting? Why such pessimism?

It turns out that her friend's mother would say after every

race, “You just didn’t meet your potential. Did you at least beat Sarah (a fellow competitor)?”

This scenario illustrates how a parent who constantly gives negative responses can build pessimism in a child.

Why is optimism important?
An optimistic child is strong, enterprising, and resilient. He or she does not wait passively for good things to happen to him or her. The optimist consciously plans, works hard to make things happen, and persists through challenges.

Research shows important benefits:
• A healthier heart and a greater ability to fight infections and survive disease
• Better response to stress
• Less likelihood to develop anxiety and depression
• More success in school, sports, social and recreational activities
• Greater accomplishments in life

How do I begin?
Does your child tend toward optimism or pessimism? Is the glass half empty or half full? Which would your child say, “It doesn’t matter… I won’t get it right anyway,” or “I did my best… I’ll get it next time”? Optimism is a learned skill that you can teach your child at home.
Here are some important tips.

Model positive behaviors and attitudes:

“This is tough, but I can do it!”

“I will find that lost pair of socks!”

Create an environment that **fosters love and trust**.
When children have a sense of security and trust at home, they view the world as a positive place to explore and try new things.

Encourage your child to view life in a positive way and to rise above negativity.
For example, one of our favorite techniques is "**Rise up! Don't dwell on it**." If someone did or said something hurtful to your child, teach your child to pause. Have her ask herself "How important is it? Will it matter in 5 minutes, 5 months, or in 5 years?" Think of the big picture.

Another is to approach mistakes calmly. Say "Oops!" and move on.

Validate your child's feelings of disappointment or sadness, but teach your child that failures and mistakes are opportunities to learn and do something different and better.

After all, in life "Sometimes you win, sometimes you learn."

Patricia Gage, PhD, NCSP and Gina Penaflor, MD, FAAP

Dr. Patricia Gage *runs Brain Smart Academics, her own private practice as a school psychologist in Stuart, Florida, and has taken the lead in many charitable organizations that help promote children's social/emotional wellness and women's health.*

Dr. Gina Penaflor, *mother of a school-aged child, tween and teen, is a primary care pediatrician in South Florida with a background in emergency and hospital medicine. She and Pat have combined their knowledge and experiences to create a* Hang-In-There *educational card series. Their mission is to help busy moms and dads lead a more rewarding (and less stressful!) parenting experience.*

To learn more, please visit their website at *www.HangNthere.com or Facebook page, or e-mail them at busymoms@HangNthere.com.*

Potty training 101: the nuts and bolts

A shout out to Trinity Day School in Solebury, PA where we spoke with a group of parents yesterday about the pearls and pitfalls of potty training. Today we share some of what we discussed.

At Trinity day School

“Will it ever end?” many parents ask. Time moves in slow motion for parents teaching their kids to use the potty. For those trapped in a potty training time warp, take heart. It’s been seven years since we first released out podcast on potty training and we’re proud to report that the parents who first listened to that podcast have moved onto new parenting challenges like helping with homework. For those in the midst of training, and those who are contemplating training, this post is for you.

Children master potty training typically between the ages of two and four years. Be patient, not everyone is “typical.” **More important than your child’s age is whether she shows she is developmentally ready to train.** These signs include:

– is generally agreeable/ can follow directions.

– gets a funny expression before passing urine or poop, or runs and hides, then produces a wet or soiled diaper.

-asks to be changed/ pulls on her diaper when it becomes wet or soiled- remains dry during the day time for at least two hours (look for a dry diaper after nap time.)

-NOT because grandparents are pressuring you to start

training their grandchild.

– NOT if the child is constipated–the last thing you want to do is to teach withholding to a kid who already withholds.

-NOT if a newborn sibling has just joined the family. A new baby in the house is often a time of REGRESSION, not progression. However, if your toddler begs to use the potty at this time, then by all means, allow him to try.

Make the potty a friendly place. Have a supply of books to occupy your child while she sits. Make sure her feet are secure on the floor if using a potty chair or on a stool if using the actual toilet. If using the real toilet for training, consider placing a potty training rim on the toilet seat to prevent your child from jack-knifing into the toilet. If your child is afraid of the bathroom, put the potty chair in the hall just OUTSIDE of the bathroom.

Have reasonable expectations based on age. A two year old's attention span is two minutes. Never force your child to sit on the potty. If he doesn't want to sit, then he isn't ready to train.

Your can lead a horse to water… Reward your child for sitting on the potty, even if she does not "produce." Reward by giving a high-five, verbal praise, or a small, cheap trinket such as a sticker. Do NOT promise your child a trip to Disney for potty training–otherwise, what will you do when she learns to ride a bike or tie her shoes? Plus, unless you are prepared to leave right away, the toddler/preschooler does not developmentally understand the concept of long term reward. Accept that she may simply enjoy sitting fully clothing on the potty while singing at the top of her lungs for a few weeks.

Let your child learn by imitation At home, have an open door bathroom policy so she can imitate you and her older siblings. At school, she will imitate her potty-trained classmates.

Initially, kids rarely tell their parents they "have to use the potty." For these kids, schedule potty visits every 2-3 hours throughout the day. Do potty checks at key times such as first waking up, right before nap, and before bedtime. Be sure to spend extra time a half an hour after meals or after a warm bath. Both meals and warmth stimulate poop!

A child is potty trained when she can do the whole deal: use the potty, help wipe, help un-dress and re-dress, and wash hands.

If the child refuses to wash hands after using the potty, she is not trained. Ultimately, the goal is for her to gain independent toileting skills. However, she will need your supervision for a while.

Important note for parents of BOYS: First potty train your son to sit for ALL business. Teach him to gently press his penis downward so pee lands in the toilet and not all over the room. Once your son stands up to urinate, he may become so excited that he may never sit down again. Better to wait until he uses the potty consistently with few accidents before teaching him to stand up. Even after he begins to stands to pee, have him sit on the potty daily to allow him time to poop.

Don't be surprised if your child trains for pee before poop. In fact, many kids go through a phase when they ask for a diaper to poop in. After all, it's frightening to see/feel a chunk of your body fall into an abyss. Dump the poop from the diaper into the potty and practice waving bye-bye.

A note about night time and naps: Potty train for when your child is awake. Your child will spontaneously, without any training, stay dry at night and during naps. Some kids sleep more soundly than others and some kids are not genetically programmed to stay dry overnight until they are elementary school aged. For more information

about bed-wetting please see our post on this topic. No amount of daytime training will affect what happens during sleep. Moderate fluids right before bed and continue putting on the diapers at night until you notice that the diapers are dry when your child wakes up. After a week of dry mornings, try your child in underwear overnight. Occasional accidents are normal for years after potty training, so you might want to put a water proof liner under your child's sheets when first graduating to sleep underwear.

Disposable training pants: We like sticking to underwear while potty trainers are awake and diapers while asleep. A reluctant trainer tends to find training pants just absorbent enough that he does not care if he is wet. However, the pants are not absorbent enough to prevent rashes from stool or urine. Plus they are more expensive than underwear AND diapers. Explain to your child "sleep diapers" are perfectly acceptable until their "pee pee learns to wake them up." Use the training pants when your child is older and is mortified by the idea of a diaper or if your family is going on a long car ride and you don't want to risk urine on a car seat.

Above all: avoid power struggles. If potty training causes tears, tantrums, or confusion then STOP TRAINING, put those diapers back on, and try again a few weeks later.

After the training, keep an eye on how often he pees and poops. Older kids get "too busy" to go to the potty. Make sure he is in the habit of emptying his bladder four to six times a day and having a soft bowel movement every day or every other day.

Ultimately… you just have to go with the flow. And remember, everything eventually comes out right in the end.

Julie Kardos, MD and Naline Lai, MD

Local Peeps, come talk with us about Potty Training!

We invite you to come out on Thursday, October 20, from 9:30 to 10:30am when we will lead a discussion for parents about a topic near and dear to all toddler parents' hearts. Join us for *Potty Training: Pearls and Pitfalls* at Trinity Day School in Solebury, PA, 6587 York Rd, Upper Solebury, PA. This talk is FREE & open to the community. Attendees from outside the school must pre-register by emailing dayschool@trinitysolebury.org with "Potty Training Talk" in the subject. There's even a potty training basket that they will raffle off at this event.

We are excited about the talk. And we are thrilled to be the inspiration for a potty training basket!

Julie Kardos, MD and Naline Lai, MD

A story of life and hope

www.twopedsinapod.org

At this time of the Jewish High Holy Days, Dr. Kardos offers us a glimpse into lessons learned as a doctor in training. This is a true story she wrote years after meeting Beth and, until recently, had only shared with a few close friends.

Tonight starts Yom Kippur and my two youngest children are asleep in their beds. As my oldest sits in the rocker next to my desk reading the last book in the *Lord of the Rings* series, my husband relaxes playing a computer adventure game. The Jewish High Holy Days are a time for reflection about the past year. But my mind goes back to a Yom Kippur Eve when I was working as a resident in the Pediatric Intensive Care Unit (PICU) as part of my pediatric training.

Residents work through most holidays, even ones they consider important. This night, I wished I had off, but I consoled myself with knowing that I would be off on Thanksgiving. Luckily I was partnered with Amy, the lead physician in the PICU.

The sickest patient that night was twelve-year-old Beth. She

had leukemia and had just started chemotherapy. Because her immune system was weak, Beth was very ill with a bacterial infection in her blood. Despite powerful antibiotics, the infection raised havoc in her body. She developed such difficulty breathing that a tube from a mechanical ventilator was placed down her throat to force air into her lungs. Even the comfort of sleep escaped her. Beth was afraid of what was happening to her body. She refused to accept medicine that could help her sleep because she was so afraid that she would never wake up.

That night, despite her incredibly ill state, she got her period. Usually when a girl's body is stressed, the body preserves all blood and the periods stop. But hers came, and because her blood cells were so abnormal from a toxic combination of infection, chemotherapy, and leukemia, she began bleeding to death. We transfused her with bag after bag of blood to keep her alive.

In the middle of the night, Beth's blood pressure suddenly plummeted so we added even more medication. Because my mentor Amy was not certain that Beth would survive the night, we called her family at the hotel near the hospital where they were staying and told them come to Beth's side. And through it all, Beth refused to sleep. Her eyes always opened in terror whenever we approached her bed. Her face was gray. Her chest rose and fell to the rhythm of the mechanical ventilator, and you could smell the fear all around her.

I stood with Amy just outside Beth's room as Amy reviewed a checklist for Beth's care. It went something like: "Ok, we just called blood bank for more blood; we called her family; we called the lab; we called the pharmacy. We are currently attending to all of her problems, we now just have to wait for her body to respond." She paused," But you know what?"

"What?" I asked her.

"We need to address her spiritual needs as well. Do we know

what religion her family is? They may want a clergy member with them."

I was startled. In the midst of all the tubes and wires of technology, Amy remembered to summon the human factor in medicine. We looked in her medical chart under "religious preference" and there it was: Jewish.

"Amy," I said, "of all nights. Tonight is Yom Kippur…the holiest night of the Jewish year."

I knew that the hospital had a Rabbi "on call" just like they had priests, nuns, ministers, and other spiritual leaders. But that night I was sure that every rabbi in Philadelphia would be at synagogue for Kol Nidre, the declaration chanted at the beginning of the Yom Kippur evening service. We were unlikely to track down a Rabbi.

Despite this, we asked her mother if they wanted us to call a Rabbi for them. She shook her head no. I remember feeling relieved, then guilty that I felt relieved. Amy left to check on another patient. Beth's mom, dad, and older sister stood together watching Beth. Her sister's hand lay on her mother's arm. Her mother's eyes darted from me to Beth to the mechanical ventilator next to the bed. Beth's eyes were closed and it was difficult to know if she even knew we were there.

Her family walked out into the hall to talk. Beth at that moment opened her eyes and started tapping on the bed with her foot to get my attention. She couldn't talk because of the tube down her throat and her hands were taped down with IVs. Yet she reached out with one hand as best she could.

I walked close to her bed so she could touch me and I asked, what is it, Beth?

Her lips formed the words around the breathing tube very deliberately, her body tensing. "Am I going to die?"

All in a split second I am thinking to myself: How do I know/it could very well happen/how can I lie to her/how can I

tell her the truth of what I fear could very well happen/how am I going to answer this child?

What I answered was, “Not tonight, Beth.”

She relaxed into her pillow but kept her eyes on mine. I waited to see if she would say anything else, but the effort to ask that one question had exhausted her. I stood, holding her hand, until her family came back into the room. Her eyes followed them to her bed and I left so they could be together.

Beth did survive the night and in fact survived a month in the PICU. She became well enough to be transferred to a regular hospital floor. By this time I was working in a different part of the hospital, but one of the oncologists pointed her out to me.

I don’t know what happened to her in the long term.

So now I tell my oldest child it’s time for him to stop reading and go to sleep, and I walk him to his room to say goodnight. My husband and I decide what time we’ll attend Yom Kippur services tomorrow. Part of me feels joined with Jews everywhere who will also be spending the next day reflecting, praying and celebrating a new year. But mostly, like every year at this time, I remember the sounds and the smells and the fear in the PICU where sickness doesn’t care who your God is or what your intentions are. I remember Amy caring enough to think about a dying child’s family religion, and always, I remember Beth.

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How to transition to milk in a cup

photo by Lexi Logan

While “drinks from a cup” is often listed as a developmental milestone for one-year-olds, it is a good idea to start teaching this skill BEFORE your child’s first birthday. Go ahead and introduce a cup when you baby is around six months old.

Here’s why six months is a great time to start a cup:

- Six-month-olds are starting to sit propped and even unsupported
- Six-month-olds can bring their hands together and pull most objects into their mouths – this is why baby proofing is so important starting at this age as well!
- Six-months-olds are usually not afraid or wary of new

things, new experiences, or new people. As an example, when I walk into the exam room and start examining a 6-month-old baby, he usually smiles and "talks" to me. When I hand him 2 wooden tongue depressors to play with, he reaches for them eagerly and puts them into his mouth as soon as he grabs them. In contrast, a 9-month-old or one-year-old will often look back at his dad when I enter the room, he might cry when I go to examine him, and may eyeball the wooden tongue depressors suspiciously.

- One-year-olds are much more willful and oppositional than 6-month-olds and so may balk at a new way of drinking.

"You mean a "sippy cup, right?"

We have an entire post devoted to sippy cups but the short of it is that even babies as young as 6 months can start learning to drink out of open cups. Parents have told me that their 6-month-old will pull their mom's water bottle to his mouth and drink from it.

The origin of the non-spill sippy cup:

According to this article in the New York Times , mechanical engineer and dad Richard Belanger first developed his own non-spillable cup because he was tired of always cleaning up his toddler's spills. In other words, **he developed the cups for parents** with an aversion to mess, not as a "stepping stone" for kids learning to drink out of a cup. His non-spill cups were specifically for *kids who already drank out of open cups but often spilled them*. He eventually pitched his prototype to Playtex, and the rest is history: non-spillable sippy cups are now ingrained into toddler culture.

So, when parents of my patients lament, "My child throws the sippy cup away! He won't suck from it!" I smile and answer, ok, take the vacuum seal or valve out or skip the sippy cup

and just give a regular open cup.

WHAT should you put in the cup?

Water is a great choice. It is healthy and does not stain so is easy to clean when your new cup-user spills it.

You can put formula or breastmilk in the cup if you want, but don't worry if your baby won't drink it. Remember, you are not replacing bottles or nursing yet, you are simply adding a cup.

After your child turns one year, you can put whole or two-percent cow's milk (reduced- fat milk) in the cup. No need for toddler formulas. Your pediatrician will guide you as whether to start with whole or the two-percent.

How much milk do kids need in their cups?

Remember that once your child weans from breast milk or formula, she no longer receives a lot of iron through cow's milk. In fact, the calcium in milk hinders iron absorption from food, so be sure to cap your child at 24 ounces of milk per day and give iron rich foods.

Most juice, even 100% juice, has the same sugar content as soda (such as Coke or Sprite), so juice is not a great choice of beverage for kids. Children should eat fruit but most do not need to drink juice.

Do I have to mix cow's milk in with the formula or breast milk to "get my child used to it?"

Not at all! Think about how you fed your baby solid foods. You didn't have to, for example, start with cereal and then mix every other food into the cereal. Just start cow's milk in a cup alongside your last supply of formula in a bottle or at the same time you are still giving breast milk. For social reasons and to make it easier for yourself later, offer "big kid milk" in cups and "baby milk" in bottles. Then when you stop giving formula, you won't need to continue to

give (and wash- ugh!) bottles anymore!

One trendy question we hear these days is: Can I give raw milk in the cup?

The answer is: NO.

Raw milk contains many bacteria, such as salmonella, Listeria, and E.coli. The reason we pasteurize milk is to get the bacterial count down. Out of 121 dairy-related outbreaks in the US reported between 1993 and 2006, 73 (60 percent) were linked to raw dairy, despite the fact that only about 3 percent of the dairy products consumed in the U.S. was unpasteurized. These statistics prompted the American Academy of Pediatrics to issue a statement in 2013 recommending against raw milk.

If your child won't drink cow's milk, that's ok too. Cow's milk is a convenient, *but not a necessary*, source of protein, fat, vitamin D, and calcium, all of which are found in other foods.

If your child is allergic to dairy or is lactose intolerant, you can offer almond milk, soy milk, or even no milk.

After one year of age, it's fine if water is the only fluid your child drinks. He can get all of his nutrition from food. Liquid intake is more for hydration than for sustenance.

A word about vitamin D: Even though cow's milk is fortified with vitamin D, continue to provide a vitamin D supplement. The recommended daily allowance of vitamin D intake starting at one year of age is 600 IU a day. Since most toddler/child vitamins contain 400 IU per tablet/gummy, most kids will take in the recommended daily allowance of 600 IU a day if they drink some milk and take any of the over-the counter chewable vitamins. If your child does not drink any milk or you prefer not to give a supplement, 600 IU a day can be achieved through yogurt or cheese that is vitamin D fortified as well

as vitamin D containing foods such as salmon and shiitake mushrooms (I know, I know… shiitake mushrooms are not usually a toddler favorite).

Beware of Grazing: Just as a "dieter's trick" is to drink eight ounces of water prior to meals to curb the appetite, too much fluid = less appetite for solids. Grazing in the day or at night hinders picky eaters from eating. Additionally, grazing milk promotes dental caries (cavities) because milk sugar constantly bathes the teeth. Even if your child initially drinks a bedtime cup of milk, remember to always brush his teeth afterwards and to eventually stop offering milk before bed. Your goal is to offer the cup with meals or snacks. Your child does not need a cup in between.

We hope this post quenched your thirst for knowledge about transitioning to a cup!

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