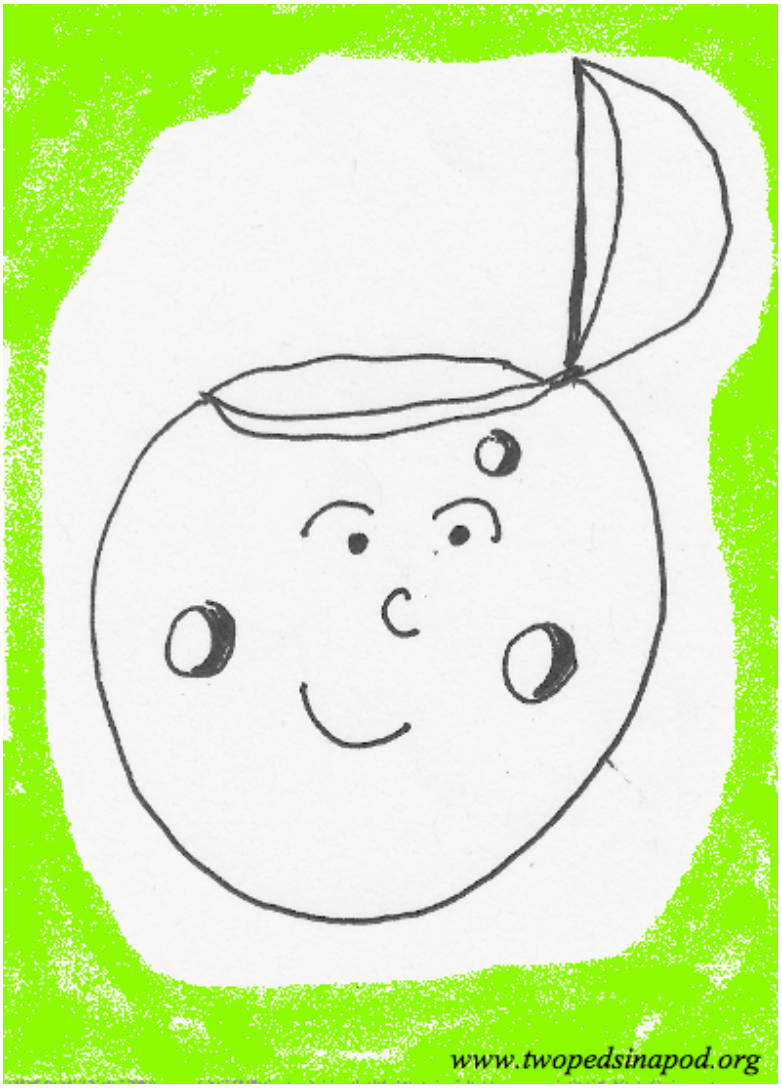
Sinus infection or a cold?



Holes in your head – sinus infections

You have a hole in your head.
Actually, you have several.
You, your children, and everyone else.

These dratted air pockets in your skull can fill with pus and cause sinus infections. Scientists hypothesize they once helped us equilibrate in water while swimming. Now, sinuses seem only to cause headaches.

Sinuses are wedged in your cheek bones (maxillary sinuses), behind your nose (ethmoid sinuses) and in the bones over your

forehead (frontal sinuses). When your child has a cold or allergies, fluid can build up in the sinuses. Normally, the sinuses drain into the back of your nose. If your child's sinuses don't drain because of unlucky anatomy, the sludge from her cold may become superinfected with bacteria and becomes too thick to move. Subsequently, pressure builds up in her sinuses and causes pain. A sinus infection of the frontal sinuses manifests itself as pressure over the forehead. The pain is exacerbated when she bends her head forward because the fluid sloshes around in the sinuses. Since frontal sinuses do not fully develop until around ten years old, young children escape frontal sinus infections.

Another sign of infection is the increased urge to brush the top row of teeth because the roots of the teeth protrude near the maxillary sinuses. Kids with sinusitis sometimes complain that their teeth hurt. Bad breath caused by bacterial infested post nasal drip can also be a sign. Occasionally kids with sinus infections develop swelling above or below the eyes, giving a puffy look to their faces.

The nasal discharge associated with bacterial sinus infections can be green/yellow and gooey. However, nasal drainage from a cold virus is often green/yellow and gooey as well. If your child has green boogies on the third or fourth day of a cold, does not have a fever, and is comfortable, have patience. The color should revert to clear. However, if the cold continues past ten days, studies have shown that a large percentage of the nasal secretions have developed into a bacterial sinus infection. To further confuse things for parents: a child can have a really yucky thick green/yellow runny nose and have "just a cold" or they can have clear secretions and have a sinus infection. In this case, the duration of symptoms is a clue to whether your child's runny nose is from a cold or from a sinus infection.

Because toddlers in group childcare often have back-to-back colds, it may seem as if he constantly has a bacterial sinus infection. However, if there is a break in symptoms, even for one day, it is a sign that a cold has ended, and the new runny nose represents a new cold virus. Pediatric trivia: the

average young child gets 8-10 colds per year, and colds last up to 10-14 days, sometimes even as long as three weeks. However, a cold seems better after 10 days even if some cough or mild nasal congestion lingers. Sinusitis is the cold that seems WORSE after ten days.

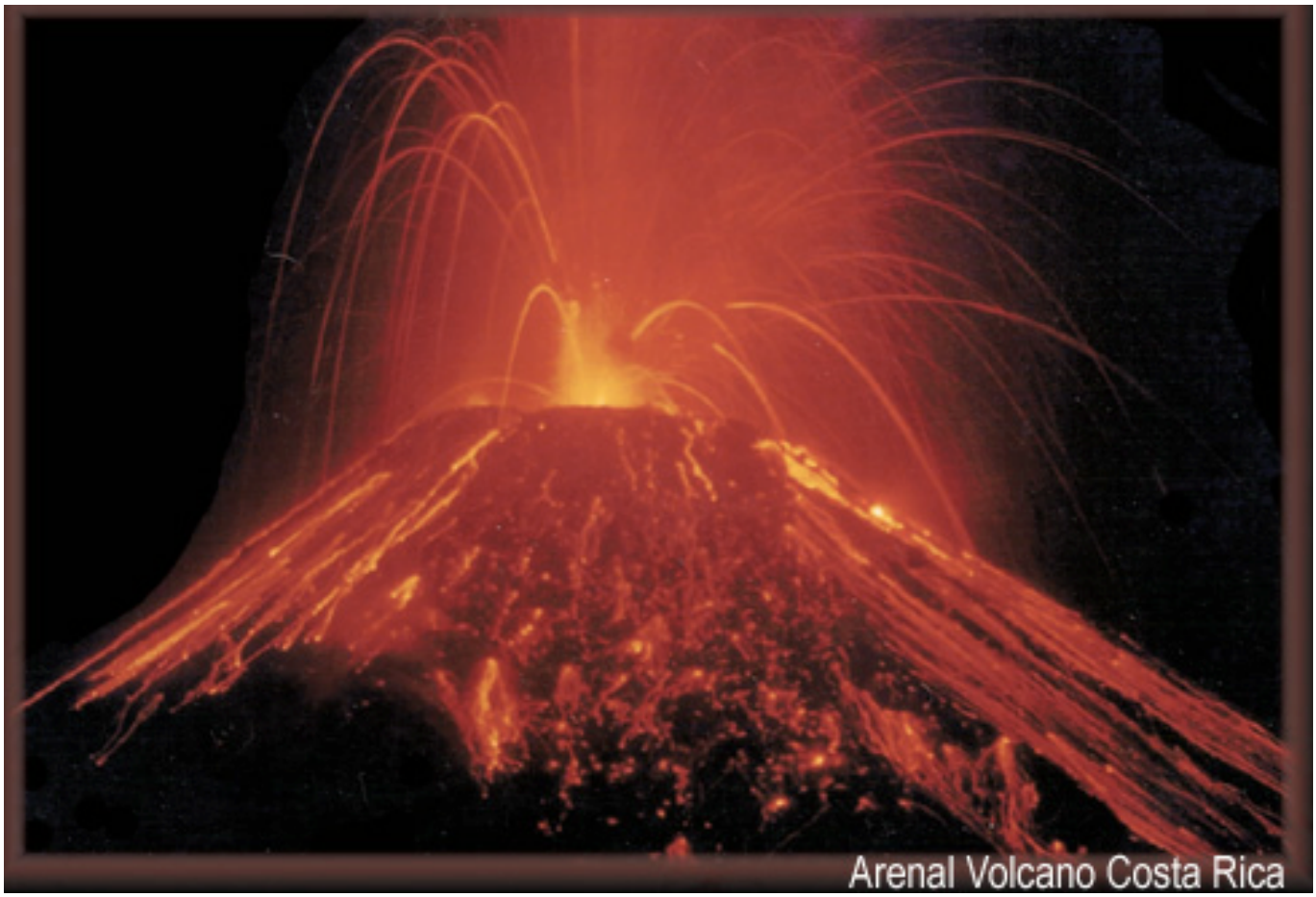
Hydrate your child well when she has a sinus infection. Your child's body will use the liquid to dilute some of the goo and the thinner goo will be easier for her body to drain. Since sinus infections are caused by bacteria, your pediatrician may recommend an antibiotic. The usual duration of the medicine is ten days, but for chronic sinus infections, two to four weeks may be necessary. Misnamed, "sinus washes" do not penetrate deep into the sinuses; however, they can give relief by mobilizing nasal secretions. When using a wash, ask the pharmacist for one with a low flow. Although the over the counter cold and sinus medicines claim to offer relief, they may have more side effects than good effects. Avoid using them in young children and infants. One safe and reliable way to soothe the nasal stuffiness of a sinus infection is to use simple saline nasal spray as often as needed.

Who knows. Someday we'll discover a purpose to having gooey pockets in our skulls. In the meantime, you can tease your children about the holes in their heads.

Naline Lai, MD and Julie Kardos, MD

How to treat your vomiting

child



“Mommy, I throwed up.”

Few words are more dreadful for parents to hear, especially at 2:00am (my children’s usual time to start with a stomach bug). In my house, I am the parent who, after the vomiting, comforts, changes pajamas and sheets, washes hands and face, and sprays the disinfectant. My husband scrubs (and scrubs, and scrubs) the rug. Little kids never throw up neatly into a toilet or into the garbage can. Sometimes even big kids can’t seem to manage to throw up conveniently.

What should you do when you have a vomiting child?

After you finish cleaning your child and her immediate environment, I suggest that you CHANGE YOUR OWN CLOTHES AND WASH YOUR HANDS! The most common cause of vomiting in kids is a stomach virus, and there are so many strains, we do not develop immunity to all of them. And trust me,

stomach viruses are extremely contagious and often spread through entire households in a matter of hours. Rotavirus, a particularly nasty strain of stomach virus, is preventable by vaccine, but only young babies can get the vaccine. The rest of us are left to fend for ourselves.

Stomach viruses usually cause several episodes of vomiting and conclude within 6-8 hours. Concurrently or very soon thereafter, the virus makes an exit out the other end in the form of diarrhea, which can last a week or so.

A hint to get through a long night: If your kid is too young to vomit into the nearest trash can, make a nice nest for her with many towels on the bathroom floor. For the older kids, put layers of towels on the pillow.

The biggest problem children face when vomiting is dehydration.

Kids need to replace fluids lost from vomiting. Pedialyte® or other oral rehydration solutions (ORS) such as Kaolectrolyte® or CeraLyte® are useful and well tolerated beverages for rehydrating kids. They contain salt, sugar, electrolytes and water, all substances that kids need when they throw up and have diarrhea.

For babies however, try to “feed through” with breast milk or formula unless otherwise directed by your child’s doctor.

Most oral rehydration guidelines are based on diarrheal illnesses such as cholera, so you will find slight variations on how to rehydrate. Basically, they all say to offer small frequent amounts of liquid. I council parents to wait until no throwing up occurs for 45 minutes to an hour and then start offering very small amounts of an ORS (we’re talking spoonfuls rather than ounces) until it seems that the vomiting has subsided.

In her house, Dr. Lai uses the two vomit rule: her kids go back to bed after the first vomit and she hopes it

doesn’t occur again. If vomiting occurs a second time, she starts to rehydrate.

Continue to offer more fluids until your child urinates- this is a sign that her body is not dangerously dehydrated. Refusing to drink? Children of all ages do better with straws, and you’d be surprised how much you can get in with a medicine syringe (available at pharmacies).

Can’t immediately get out to the store?

The World Health Organization has recommended home based oral rehydration solutions for years in third world countries. Also, while the oral rehydration solutions are ideal, any fluid is better than none for the first hours of a stomach bug. You can give older kids watered down clear juices, broth or flat ginger-ale with lots of ice. Now, some kids hate the taste of Pedialyte®. Plain, unflavored Pedialyte® splashed with juice often goes down better than the flavored varieties. For some reason, plain water tends to increase nausea in sick kids and copious amounts of plain water can lower the salt in a child’s bloodstream. So, offer a fluid other than plain water while your child is vomiting.

Even if your child drinks the Pedialyte®, once the stomach symptoms have subsided, don’t forget that Pedialyte®, while excellent at “filling the tank,” has no nutrition. The gut needs nutrition to overcome illness. Start to offer small amounts of food at this point. Easy-to-digest foods include complex carbohydrates such as rice, noodles, toast with jelly, dry cereal, crackers, and pretzels. Additionally, give protein such as bits of turkey or baked chicken or tofu.

Thicker fluids such as milk and orange juice do not sit as well in upset bellies, nor do large quantities of anything, food or drink. So offer small bits of nutrition

fairly frequently and let kids eat as their appetite dictates. Warning- just when everything blows over, toddlers in particular may go a day without vomiting, then vomit one more time as a last hurrah.

Vomiting from stomach viruses typically does not cause severe pain.

A child curled up whimpering (or yelling) on the floor with belly pain might have something more serious such as appendicitis, kidney stones, or a urinary tract infection. Call your child's doctor about your child's vomiting if you see any of the following:

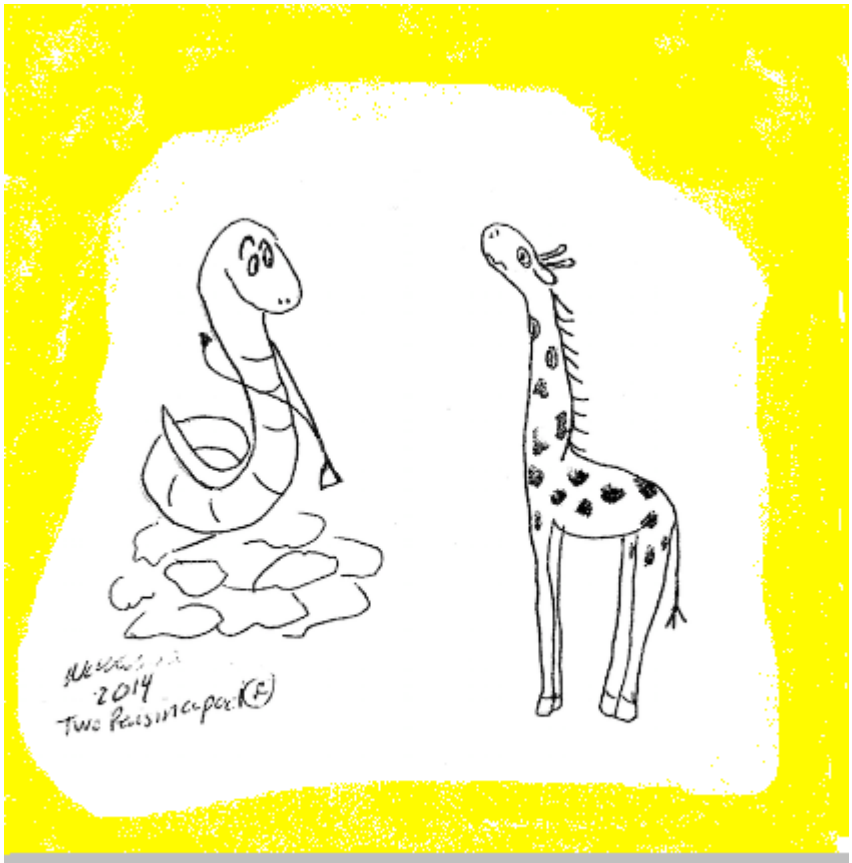
- Blood in vomit or in stools
- Severe pain accompanying vomiting (belly pain, headache pain, back pain, etc.)
- No urine in more than 6 hours from the time the vomiting started (dehydration)
- Change in mental state of your child- not responding to you appropriately or inconsolable
- Vomit is yellow/green
- More fluid is going out than going in
- Illness not showing signs of letting up
- Lips and mouth are dry or eyes sunken in
- Your own gut tells you that something more is wrong with your child

Of course, when in doubt, call your child's doctor .

Hope this post wasn't too much to stomach!

Julie Kardos, MD and Naline Lai, MD

Treat your child's sore throat



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

Many times parents bring their children with sore throats 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 "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, on the other hand, feel great on sore throats. Tell your child that the first three sips of a 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 6 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 and 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. **Do not** use the Maalox formulation which contains bismuth subsalicylate. 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 does not cause cough, 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 posts: "Strep throat Part 1: what is it, who gets it and why do we care about it" and "Strep throat Part 2: diagnosis, treatment, and when to worry."

Any **sore throat that prevents swallowing or prevents your child from opening his mouth fully, pain that is not alleviated with the above measures, fever of 101F or higher for more than 3-4 days, or a new rash** all merit a prompt visit to your child's doctor for further evaluation. Please 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

Breast feeding your newborn: the first two weeks

Buy this- it's the latest breast feeding gizmo
I don't know how moms ever survived without it.

I always tell new moms that if you can breastfeed for two weeks, then you can breastfeed for two years. The point is, while our species has been breastfeeding for millions of years, sometimes it's not intuitive. Getting to the two week point isn't always easy, but once you're there, you'll be able to continue "forever."

So, how to get through those first two weeks? Practice. Fortunately, your newborn will become hungry for a meal every two hours, on average, giving you many opportunities to practice. For the first few meals, a newborn can feel full after eating only one teaspoon of colostrum (the initial clear milk). The size of a person's stomach is the size of his fist. For a baby, that's pretty small. So relax about not making a lot of milk those first few days. But remember, your baby's needs will change and she will start to require more milk. A nursing baby tells the mom's body to produce more milk by stimulating the breast. Nurse more often and production will increase. Traditionally, moms are told to attempt a feeding every 2-3 hours. But babies do not come with timers, and Dr. Lai tells moms the interval of time between feeds is not as important as the number of times the breast is stimulated. Around 8-12 feedings a day is usually enough to get a mom's milk to "come in."

Some lactation consultants advocate allowing the baby to feed on one breast as long as she wants before switching sides. I am more of a proponent of efficiency (I had twins, after all). What works well for many of my patients for the first few days is to allow the baby to nurse for 5-8 minutes on one breast, then break suction and put the baby on the other breast for the same amount of time. If your baby still seems hungry, you can always put her back on the first breast for another five minutes, followed by the other breast again for five minutes. Work your way up to 10-15 minutes on each side once your milk is in, which can take up to one week for some women. Nursing the baby until a breast is empty gives the baby the rich hind milk as well as the initial, but less fatty fore milk. Close mom's kitchen for at least an hour after feedings. Beware of being used as a human pacifier.

Advantages for this feeding practice:

1. Prevents your newborn from falling asleep before finishing a feeding because of the activity of changing sides
2. Stimulates both breasts to produce milk at every feeding
3. Prevents mom from feeling lopsided
4. Prevents mom from getting too sore
5. Allows time in between feedings for mom to eat, drink, nap, use the bathroom, shower (remember, these are essentials of life)
6. Teaches baby to eat in 30 minutes or less.

I have seen improved weight gain in babies whose moms breast feed in this way. However, if your baby gains weight well after feeding from one breast alone each feeding, or if you are not sore or dangerously fatigued from allowing your baby to feed for a longer time, then carry on!

How do you know if your baby is getting enough milk? While all babies lose weight after birth, babies should not lose

more than 10% of their birth weight, and they should regain their birth weight by 2-3 weeks of life. Young babies should also pee and poop a lot (some poop after EVERY feeding) which is a reflection of getting enough breast milk. Count on about one pee diaper for each day of life and one poop diaper for each day of life (three days old = 3 poop diapers and 3 urine diapers). Yellow poop is a sign that milk in going through your baby. Good urine output shows that your baby is well hydrated. Your child's doctor will weigh your baby by two weeks of life to make sure he "makes weight."

Many good sources can show you different suggestions for feeding positions. Experiment to see which is most comfortable for you and your baby. If you notice one spot on a breast is particularly full and tender, position your baby so that his chin points towards that spot. This may make for awkward positions, but in this way, he drains milk more efficiently from the full spot.

When you first get home with your newborn, if the visitors in your house aren't willing to do your dishes, then kick them out. It's time to practice feeding.

Helpful websites:

To find a lactation consultant near you see the International Lactation Consultant Association

For our moms across the world and the States- La Leche League International and The Children's Hospital of Philadelphia- breastfeeding tips for beginners

For moms in Bucks, Mongomery and Philadelphia Counties, Pennsylvania- Nursing Mother's Advisory Council

Julie Kardos, MD with Naline Lai, MD

Getting back to basics: How do vaccines work?

Recent comments by politicians have brought vaccines back into the public eye. In this post, we get down to basics.

Did you ever wonder how a vaccine works?

To understand how vaccines work, I will give you a brief lesson on the immune system. Trust me, it is interesting. Let me give you an example of me. When I was eight, I had chicken pox. It was a miserable week. I started out with fever and headache, then suffered days of intense body itching from blister-like spots, and ultimately, because I scratched off some scabs, ended up with scars. During this time, my immune system cells worked to battle off the chicken pox virus. Immune cells called memory cells also formed. These cells have the unique job of remembering (hence the name “memory cells”)

what the chicken pox virus looks like. Then, if ever in my life I was to contact chicken pox again, my memory cells could multiply and fight off the virus WITHOUT MY HAVING TO GET SICK AGAIN WITH CHICKEN POX. So after I recovered, I was able to play with my neighbor even while he suffered with chicken pox. I returned to school where other children in my class had chicken pox, but I did not catch chicken pox again. Even now, as a pediatrician, I don't fear for my own safety when I diagnose a child with chicken pox, because I know I am immune to the disease.

This is an amazing feat, when you think about it.

So enter vaccines. A vaccine contains some material that really closely resembles the actual disease you will protect yourself against. Today's chicken pox vaccine contains an altered form of chicken pox that is close to but not actually the real thing. However, it is so similar to the real thing that your body's immune system believes it is, in fact, real chicken pox. Just as in the real disease, your body mounts an immune response, and makes memory cells that will remember what the disease looks like. So, if you are exposed to another person with chicken pox, your body will kill off the virus but YOU DON'T GET SICK WITH THE CHICKEN POX. What a beautiful system! Rather than thinking about a vaccine as a foreign substance, think of it as a substance that is able to strengthen your body's natural immune system.

Before chicken pox vaccine, about 100 children per year in the US died from complications of chicken pox disease. Many thousands were hospitalized with pneumonia, skin infections, and even brain damage (encephalitis) from chicken pox disease. Now a small injection into the arm can prevent a disease by creating the same kind of immunity that you would have generated from having the disease, only now you have one second of pain from the injection instead of a week of misery and possible permanent disability or death. I call that a Great Deal!

I used the example of chicken pox because the vaccine was invented during my own lifetime. However, I could have used the example of polio, which, prior to its vaccine development in 1955, paralyzed 10,000 children per year in the United States, or measles, which infected 4 million children per year and killed 3000 per year in the United States before doctors began to give children a vaccine against measles in 1963.

All vaccines operate by this principle: create a safe environment for your immune system to make memory cells against a potentially deadly disease. Then when you are exposed to someone who actually has the disease, you will not "catch" it. Your body will fight the germs, but you do not become sick. If everyone in the world were vaccinated, then the disease itself would eventually be completely eradicated. Even if MOST people were vaccinated, this disease eradication can occur, because the majority of immunized people protect the few who are too young or too ill to receive vaccines themselves. This happened with small pox, a disease that killed 50 percent of infected people. There is no longer small pox because nearly everyone on earth received the small pox vaccine. Now we do not need to give small pox vaccine because the disease no longer exists. This is a huge vaccine success story.

Friedrich Nietzsche said "What doesn't kill us makes us stronger." We pediatricians feel this is unacceptable risk for children. We would rather see your child vaccinated against a disease in order to become immune rather than risking the actual disease in order to become immune. The vaccines that we give children protect against diseases that can cause serious, lifelong disability or death.

Hopefully this blog post answers your questions about how vaccines work. For more details or more in-depth explanations, I refer you to the AAP (American Academy of Pediatrics) website www.aap.org, the Immunization Action Coalition, Children's Hospital of Philadelphia's Vaccine

Education Center, and the book *Vaccines: What You Should Know*, by pediatricians Dr. Paul Offit and Dr. Louis Bell.

Julie Kardos, MD and Naline Lai, MD

For more information about vaccines, please see our prior posts: Should I vaccinate my child?, Closure: there is no link between the MMR vaccine and autism, Fact or Fiction: a flu vaccine quiz for all teachers, babysitters, parents, and anyone else who breathes on children, Do vaccines cause autism?, Measles outbreak: would you recognize measles in your child?, A vaccine parable , and Are my teen’s vaccines up to date?

In need of school snack ideas?

It's only a few weeks into the school year and we are running out of snack ideas for our kids. We looked back and found a couple of our favorite posts for snacks by guest bloggers Dr. Roxanne Sukol and Health Coach Mary McDonald . Click here if you are in the same boat:

Packing your child's school lunch: Beware of junk food disguised as healthy food

Overhauling the Sports Snack Stand

Julie Kardos, MD and Naline Lai, MD

Is my kid’s backpack too heavy?

Dr. Lai staggers under the load of her high schooler’s back pack

Although we see in the news that ebooks are replacing textbooks, our kid’s backpacks look heavier than ever. Returning is physical therapist Dr. Deborah Stack with backpack pointers. -Drs. Lai and Kardos

With the return to school, we wanted to remind you of some healthy backpack tips including adjusting your backpack. I recall the first day of school one year when the “first day of school” photo showed my not-quite-100-pound child bending in half under the weight of a backpack, trombone, lunchbox and art portfolio. I quietly decreed that it would not happen again. To make sure it does not happen at your house either, consider a few suggestions to keep your children healthy:

1. A traditional backpack with **two shoulder straps** distributes the weight more evenly than a pack or messenger bag with a single strap.
2. Look for **wide, padded straps**. Narrow straps can dig in and limit circulation.
3. Buckle the **chest or waist strap** to distribute weight more evenly.
4. Look for a **padded back** to protect your child from pointy pencils etc.
5. Look for a **lightweight pack** that does not add much overall weight.
6. **Multiple compartments** can help distribute weight.
7. **Place heavier items** close to the spine instead of in front pockets.
8. **Compression straps** on the sides or bottom of the backpack can compress the contents of the backpack and stabilize the articles.
9. **Reflective material** allows your child to be visible on those rainy mornings.
10. **A well fitting backpack** should match the size of the child. Shoulder straps should fit comfortably on the shoulder and under the arms, so that the arms can move freely. The bottom of the pack should rest in the contour of the lower back. The pack should “sit” evenly in the middle of the back, not “sag down” toward the buttocks.

How much should that tike be toting? The American Academy of Pediatrics recommends no more than 10-20 percent of body weight and the American Physical Therapy Association recommends no more than 15 percent of a child’s weight. Here’s a chart to give you an idea of the absolute maximum a child should carry in a properly worn backpack:

Child's Weight (pounds)	**Maximum Backpack Weight (based on 15% of body weight)** (pounds)
50	7.5
60	9
70	10.5
80	12
90	13.5
100	15
110	16.5
120	18
130	19.5

Here are some ideas to help lighten the load, especially for those middle school kids who have a plethora of textbooks:

1. Find out of your child's textbook can be accessed on the internet. Many schools are purchasing access so the students can log on rather than lug home.
2. Consider buying an extra set of books for home. Used textbooks are available inexpensively online.
3. Limit the "extras" in the backpack such as one free reading book instead of five. I am not exaggerating; one day I found five free reading books in my child's backpack!
4. Encourage your child to use free periods to actually study, and leave the extra books in his locker.
5. Remind your child to stop by her locker between classes to switch books rather than carrying them all at once.
6. Consider individual folders or pockets for each class rather than a bulky 3-ring notebook that holds every subject.

You may need to limit the load even further if your child is still:

- Struggling to get the backpack on by herself
- Complaining of back, neck or shoulder pain
- Leaning forward to carry the backpack

If your child complains of back pain or numbness or weakness in the arms or legs, talk to your doctor or physical therapist.

When used correctly, backpacks are supported by some of the strongest muscles in the body: the back and abdominal muscles. These muscle groups work together to stabilize the trunk and hold the body in proper postural alignment. However, backpacks that are worn incorrectly or are too heavy can lead to neck, shoulder and back pain as well as postural problems. So choose wisely and lighten the load. Happy shopping!

Deborah Stack, PT, DPT, PCS
With nearly 20 years of experience as a physical therapist, Dr. Stack heads The Pediatric Therapy Center of Bucks County in Pennsylvania. She holds both masters and doctoral degrees in physical therapy from Thomas Jefferson University.

Mommy, my friend dumped me

Dr. Kardos says she still remembers when her friend dumped her back in 7th grade. Guest blogging for Two Peds in a Pod, is child and adolescent counselor Dina Ricciardi with advice to help walk your kids through the experience.

It can happen very quickly, and often without explanation: your son or daughter gets "dumped" by his or her best friend or group of friends. One minute they are inseparable; the next, your child is left out and being ignored, and is completely bewildered as to why or what happened. Welcome to cliques, a typical part of the tween and adolescent landscape. While enduring these shifts in peer relationships can be extremely painful for both of you, there are some things you can do to help your child emerge safely on the other side of the experience.

Do empathize. Make sure your child knows that you understand why they are upset, and that you would be too.

Do take your child's grief seriously. We adults know that friendships change and shift over time, and that we all survive. However, your child may see this as the worst thing that has ever happened to her, and she may be right.

Don’t downplay your child’s pain. It’s normal for him to feel hurt and rejected, and to question his own actions and the authenticity of the friendship.

Do keep an eye out for bullying or name-calling. If the situation seems to require it, enlist the support of school personnel to monitor things under their watch.

Don’t disparage or belittle the offending friend(s). It might feel good in the moment, but it can set the wrong example and make it difficult for your child to reconcile if the opportunity presents itself.

As a parent, it is hard to watch your child suffer. Our instinct is often to try to fix the situation, which we need to resist. Part of adolescence is allowing our children to develop their own identity and to learn relationship skills. Through their peer relationships, they learn sophisticated concepts such as trust, loyalty, empathy, compassion, and tolerance. They also start to encounter difficult emotions such as jealousy. The most important thing we can do as parents is be available to help our children sort out their feelings and to give them a different perspective. We can also help them discover that while peers are important, they can be strong and fine on their own, and do not need other people to give them their identity. This helps them value themselves as individuals. In the process, maybe we parents learn something new also. Buckle in; it can be a bumpy ride!

Dina Ricciardi, LSW, ACSW

Dina Ricciardi is a psychotherapist in private practice treating children, adolescents, and adults in Doylestown, PA. She specializes in eating disorders 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.

Dr. Lai adds: Help your kids cultivate their interests. As they do their interests, they will look around and find that those kids will become their friends. The hardest part about adolescence is figuring out your own interests, and not those of your peers.

Does my baby have GERD or spit-up?

Baby spew doesn’t always require reflux medications

In our office, two-month-old Max smiles ear to ear, naked except for a diaper and a bib. His worried mom asks me about the large amounts of spit up Max spews forth daily. “He spits up after every feeding. It seems like everything he eats just

comes back up. It even comes out of his nose!" she says. Max gained the expected amount of weight, an average of one ounce per day, since his one-month check-up. He breastfeeds well and accepts an occasional bottle from his dad. Even after spitting up and drenching everything around him, he remains comfortable and cheerful. He is well hydrated, urinates often, and poops normally.

In short, Max is a "happy spitter" Other than creating piles of laundry, he acts like any healthy baby.

Contrast this to two-month-old "Mona." She also spits up frequently. Sometimes it's right after a feed and sometimes an hour later. She seems hungry, yet she'll cry, arch her back, and pull off the nipple while feeding. She cries before and after spitting up. Her weight gain is not so good– she averaged one-half ounce of gain per day since her one-month visit. She seems more comfortable when upright and more cranky lying down.
Mona is **not** a "happy spitter."
Last story and then the lesson:
"Chloe" is a two-month-old baby who cries. Often. Loudly. Although most of the wailing occurs in the late afternoon and early evening, she also cries other times. She eats great and in fact, seems very happy while she feeds. She smiles at her parents mainly in the morning. She also smiles at her ceiling fan and the desk lamp. Movement calms her and her parents worry that she spends excessive time rocking in their arms or in her swing. Her cries pierce through walls and make her parents feel helpless. She often spits up during crying jags, and erupts with gas. She gained weight well since her last visit.
Here's the lesson:
All babies cry. All babies pee and poop. All babies sleep (at times). AND: all babies spit up. The muscle in the lower esophagus that keeps our food and drink down in our stomachs and prevents it from sloshing upwards, called the "lower esophageal sphincter," is loose in all babies. The muscle naturally tightens up and becomes more effective over the first year of life, which is why younger babies tend to spit

up more than older babies.
Max has **GER (**gastroesophageal reflux) , Chloe has **GER/ colic** and Mona has **GERD (**gastroesophageal reflux disease)**.** Max and Chloe have physiologic, or normal, reflux. Mona has reflux that interferes with her mood, her feedings, and her growth.

GER, GERD **and** colic (excessive crying in an otherwise healthy baby) improve by three to four months of age. If your baby cries often (enough to make you cry as well) then you should see your baby's pediatrician to help determine the cause. It helps, before your visit, to think about when the crying occurs (with feedings? At certain times of the day?), what soothes the crying (feeding? walking/rocking?) and other symptoms that accompany the crying such as spitting up, fever, or coughing. Keeping a three day diary for trends can help pinpoint a diagnosis. We worry a lot when the babies are not "spitting up" but are actually "vomiting." Spit blobs onto the ground. Vomit shoots to the ground. Vomit which is yellow, is accompanied by a hard stomach, is painful, is forceful (think Exorcist), or enough to cause dehydration, all may be signs of blockage in the belly such as pyloric stenosis or vovulus. Seek medical attention immediately.

The treatment for Max, the happy spitter with GER? Lots of bibs for baby and extra shirts for his parents.

Treatment for Chloe, the crier? Patience and tincture of time. You can't spoil a young baby, so hold, rock and sway with her to keep her calm. Enlist a baby sitter or grandparents to help.

The treatment for Mona, the baby with GERD? **Small, frequent feedings** to prevent overload of her stomach, **adding cereal any bottle feeds** to help thicken the milk and weigh down the liquid, thus preventing some of the spit up (ask your doctor if this is appropriate for your baby), and **holding her upright** after feeds for 15-20 minutes. Physicians **no longer advocate** inclining the crib. To prevent Sudden Infant death Syndrome,

she should still be placed on her back to sleep on a flat, firm surface. Sometimes, pediatricians prescribe medication that decreases the acid content of the stomach to help relieve the pain of stomach contents refluxing into the esophagus.

Treatment for parents? Knowing that someday your baby will grow up, no longer need a bib, and probably have a baby who spits up too.

Julie Kardos, MD with Naline Lai, MD

Marijuana: Hashing out Fact from Fiction

With some states now legalizing pot for recreational use, drug education for kids has never been more critical. The American Academy of Pediatrics released a policy statement this past year opposing legalization because of its potential harm to children, teens, and young adults. We welcome Dr. Shannon Murphy who dispels myths surrounding marijuana. – Drs. Kardos and Lai

Why is pot so different today than 30 years ago? Pot is **5 times** stronger than the 1980's.

THC, the psychoactive ingredient in the plant, previously hovered around 3%. Now the average THC level is closer to 16%. As of this year, some plants have been tested with levels reaching between 20-30% THC. There is a new form of pot known as hash oil that is almost pure THC with levels around 90%

I heard pot was not addictive. Is that true? Pot **is addictive**.

In fact, the younger you are when you start using pot, the more likely you are to get addicted.10% of adults and 17% of young adults who try pot will become addicted to it. If one chooses to use on a daily or near daily basis, the addiction rate climbs to 25-50%.

How long does pot stay in your body? Pot is different from many other drugs because it can stay in your body for days after use.

In addition, the more you use pot, the longer it stays in your body. For regular users, it can remain in your body for several weeks. As a result, there is a sub acute impairment that persists with many users once the initial “high” has worn off.

When used, pot is distributed throughout one’s body. These areas include the brain and spinal cord, heart, lungs, muscles, and fatty tissues. In fact, it is stored in fatty tissue. If one is pregnant and one uses pot, not only will the mom be affected by pot, but so will her unborn child. It also concentrates in breast milk. People who use marijuana should **NOT** breastfeed their baby.

Isn’t pot safe to use? I heard it was safer than other drugs. Pot is harmful to the brain, heart, and lungs.

Regular use of marijuana, particularly at a young age, can create biochemical and structural changes to the brain. Some of these changes are not reversible. Moreover, the effects are dose dependent. The more you use, the more likely to affect

change.

Marijuana causes cognitive impairment. It harms learning, memory, attention, and critical decision-making. A recent study showed that regular use of marijuana at a young age causes a **permanent** decrease in IQ of up to 8 points.

Marijuana is linked to the development of mental health issues including anxiety, depression, and psychosis. Research has shown that regular daily to weekend use of pot increased one's risk of psychosis 3-5 times that of the general population. Sadly, we are seeing this played out in states like Colorado where people have died from psychosis related events.

The American Lung Association has reported that pot has more cancer causing agents than tobacco smoke. Like tobacco, it causes chronic cough, wheeze, phlegm production, and frequent infections.

Marijuana has cardiac effects as well. Temporal links have been found between using pot and arrhythmias, stroke, and other major cardiac events.

What are "edibles"?

In 2014, with the legalization of pot in Colorado, the marijuana industry began selling food products with infused THC. These products, which include candy, cereal, pop tarts, and sodas, are indistinguishable from regular food.

In fact, exposure of kids to marijuana increased by 200% over this last year because of these products. These accidental poisonings were secondary to exposure of kids to edibles typically in their home. Many kids ended up in the ER, some with serious complications like seizures and difficulty breathing.

What does "dabbing" mean?

Dabbing is inhaling vapors from heating a concentrated form of

pot. Dabs, which are also known as BHO (butane hash oil), “budder”, “honeycomb”, or “earwax” contain much higher concentrates of THC, usually upwards of 90%. Dabs are much stronger than a single joint and the high is administered all at once.

How does smoking pot affect driving?

Driving high is dangerous to the driver, others in the vehicle, and people sharing the road. In fact, marijuana is the number one illicit drug found in the blood stream of drivers involved in fatal car accidents.

Pot impairs skills needed to drive safely. It negatively impacts alertness, coordination, and reaction time.

Pot and alcohol don’t mix. Using both drugs at the same time has been shown to increase the THC level in one’s blood stream. This makes for a deadly combination on the road.

Is it okay to use pot while pregnant?

It is **NOT** okay to use pot while pregnant. As mom gets high and feels the effects of the drug, so does the unborn child.

Studies have shown that children exposed to marijuana in utero have lower scores on visual and motor coordination as well as lower scores on visual analysis and problem solving. In utero exposure is also associated with decreased attention span and behavioral problems. Finally, studies have shown that teens are more likely to be marijuana users if their mom used while pregnant.

What if my teen says that since pot isn’t a big deal anymore and many of their friends are using it?

Now more than ever, it is incredibly important to speak clearly regarding the risks of pot use. Many teens see legal as meaning safe, so we are entering a critical time when it comes to our kids and marijuana use. Here are a few

suggestions when it comes to talking to your kids about drug use in general.

Talk early and often. This should not be a one-time conversation.

Make sure your child knows your rules on drug use and set clear consequences if these rules are broken. Role-play real life situations so kids can know how to respond when confronted with scenarios that may involve drugs.Base education about pot and other drugs on facts.

Check out the National Institute of Drug Abuse website for up to date information. To learn more visit www.learnaboutsam.org .

Shannon Murphy, MD, FAAP

Dr. Murphy is a board certified general pediatrician who currently serves on the American Academy of Pediatrics Practice Advisory Committee for Adolescent Substance Use. She heads a non-profit coalition, SAM Alabama, whose goal is to educate parents and kids on the public health issues and safety concerns associated with marijuana.