

Flu or a cold? How to tell the difference



“Now what kind of soup did the doctor recommend? Was that tomato soup? Mushroom barley?”

Happy New Year and welcome to Flu Season 2017! Parents ask us every day how they can tell if their child has the flu a cold. Here's how:

Colds, even really yucky ones, start out gradually. Think back to your last cold: first your throat felt scratchy or sore, then the next day your nose got stuffy or then started running profusely, then you developed a cough. Sometimes during a cold you get a fever for a few days. Sometimes you get hoarse and lose your voice. Kids are the same way. In addition, they often feel tired because of interrupted sleep from cough or nasal congestion. This tiredness leads to extra crankiness.

Usually kids still feel well enough to play and attend school with colds, as long as they well enough to participate. The average length of a cold is 7-10 days although sometimes it takes two weeks or more for all coughing and nasal congestion to resolve.

Important news flash about mucus: the mucus from a cold can be thick, thin, clear, yellow, green, or white, and can change from one to the other, all in the same cold. The color of mucus does NOT tell you if your child needs an antibiotic and will not help you differentiate between a cold and the flu.

The flu, caused by influenza virus, comes on suddenly and makes you feel as if you've been hit by a truck. Flu always causes fever of 101°F or higher and some respiratory symptoms such as runny nose, cough, or sore throat (many times, all three). Children, more often than adults, sometimes will vomit and have diarrhea along with their respiratory symptoms, but contrary to popular belief, there is no such thing as "stomach flu." In addition to the usual respiratory symptoms, the flu causes body aches, headaches, and often the sensation of your eyes burning. The fever usually lasts 5-7 days. All symptoms come on at once; there is nothing gradual about coming down with the flu.

So, if your child has a runny nose and cough, but is drinking well, playing well, sleeping well and does not have a fever and the symptoms have been around for a few days, the illness is unlikely to "turn into the flu."

Remember: colds = gradual and annoying. Flu = sudden and miserable.

Fortunately, a vaccine against the flu is available for all kids over 6 months old (unfortunately, the vaccine isn't effective in younger babies) that can prevent the misery of the flu. In addition, vaccines against influenza save lives by preventing flu-related complications that can be fatal such as pneumonia, encephalitis (brain infection), and severe dehydration. Even though we are starting to see a lot of flu, it is not too late to get the flu vaccine for your child, so please schedule a flu vaccine ASAP if your child has not yet received one for this season. Parents and caregivers should also immunize

themselves- we all know how well a household functions when Mom or Dad have the flu... not very well!

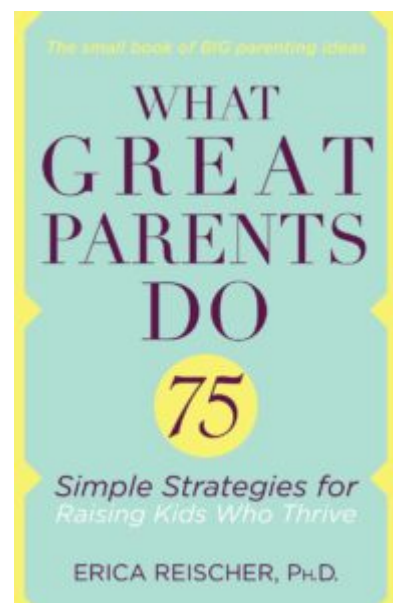
Be sure to [read our guest article on ways to prevent colds and flu](#) and our thoughts on [over the counter cold medicines](#). Now excuse us while we go out to buy yummy-smelling hand soap to entice our kids to wash germs off their hands. After that you'll find us cooking up a pot of good old-fashioned chicken soup, just in case...

Julie Kardos, MD and Naline Lai, MD
revised from our 2009 and 2015 posts

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Motivating Kids - Sticker charts aren't always the answer

As we think about how to keep our parenting New Year's resolutions, we find interesting advice from a fellow board member of Happy Healthy Kids. In her new book, WHAT GREAT PARENTS DO: 75 Simple Strategies for Raising Kids Who Thrive, Dr. Erica Reischer, a California based psychologist and parent educator cautions against motivating kids solely through reward economies such as sticker charts. – Drs. Lai and Kardos



Here's an excerpt:

“REWARD ECONOMY” IS a term I coined for the arrangements that many parents make with their children to motivate “good” behavior, such as paying for chores or routinely using sticker charts that trade good behavior for prizes or rewards (even if the reward is something wholesome like books). I call them reward economies because they can create a transactional system in which children learn to trade their desirable behavior for a reward.

The problem with reward economies is not that they don’t usually work to produce the desired behavior—if you have the right reward, these systems often appear to work well. As research has shown, the problem is that, over time, reward economies may negatively affect children’s motivation and may also create an expectation in children that they should be compensated for activities that are part of being a responsible and helpful member of the family.

One telltale sign that you’ve inadvertently created a reward economy in your family: When you ask your kids to do something outside of their regular tasks and to-dos, such as *“Please go fold the laundry,”* and they reply, *“What will you give me?”* Another sign: You tell them you’ll give them a reward/prize/sticker if they do something like helping to clean the kitchen, and they respond, *“No, thanks,”* and don’t feel obliged to help since they aren’t accepting the “compensation” you are offering.

Although sticker charts and similar systems seem like a good solution in the short term—we get helpful and cooperative behavior—in the long term we may be inadvertently creating a bigger problem: children who see their role in the family as a job for which they receive compensation. Moreover, reward economies often don’t give children many opportunities to develop self-discipline and self-mastery, which are critical life skills.

You might be wondering what could possibly be motivating about

many of the things we ask our kids to do: homework, chores, etc. My response is this: Kids who learn how to do what needs to be done—even if they don't feel like doing it—develop a strong sense of autonomy, competence, and self-mastery. There are similar benefits for kids who learn how to stop themselves from doing something desirable in the here and now in order to achieve an even more desirable future outcome (e.g. delayed gratification, as with the well-known marshmallow study).

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TRY THIS:

If you currently use sticker charts or similar reward systems, and you decide to stop, start by letting your kids know that you are going to make that change. (Sticker charts, however, can be used to good effect as a simple tracking chart, to help kids visualize their to-dos and track their progress. The key difference between a reward chart and a tracking chart is that the latter does not involve earning rewards. So kids might put a sticker on their chart to show that they finished cleaning their room, with the sticker being just a satisfying visual symbol of completion.) If they are in the middle of earning something important to them, let them finish and get their prize (that is, follow through on the commitment you made to them when you offered the incentive).

Your primary tools for rewarding good behavior going forward will be your acknowledgment and praise. For tasks your kids don't like or don't want to do, use empathy, reason, and especially rehearsals.

If your kids seem to ignore you when you make a request, first be sure they have actually heard you. Give them a reason to go with your request and, if you have to ask a second time, add fair warning of consequences. Other useful tools are scaffolding and rehearsals. In scaffolding, parents provide support and assistance in many different areas of their

children's lives (scaffolding), while avoiding doing the work itself (building). You may also have to be more involved in following up.

For example: "Sweetie, in five minutes, it will be time to clean up your toys in the living room." "Noooo... I don't want to." "I know you don't want to, honey. You wish you could just keep playing (empathy). At the same time, we all share the house, so you need to do your part to keep it clean (request/reason)." "Nooo..." (Or silence/ignoring)

Now go over to your child and try to involve her in cleaning up. Try reframing to make the activity more appealing (e.g., sing a cleanup song or have a cleaning contest). If she still refuses to help, matter-of-factly restate your request, and then give fair warning of consequences.

"Honey, it's time to clean up now. I know you would rather leave your toys on the floor. If you don't help clean up, then I will keep the toys that I find in the living room for [insert appropriate time frame for your child's age] since you aren't being responsible for them (fair warning)."

If necessary, follow through on your consequence of keeping the toys for the time you specified.

To avoid a repeat of this situation in the future, stage a rehearsal with your child in which she will practice cleaning up in a "pretend" scenario.

If she does help, be enthusiastic and specific in your praise: "Look we did it and the living room looks so organized! Even though you didn't want to clean up, I'm really proud of you for being a helper and putting all your cars in the box." Remember to praise your child for any part that she did well, even if she didn't meet all your expectations. Praise reinforces good behavior.

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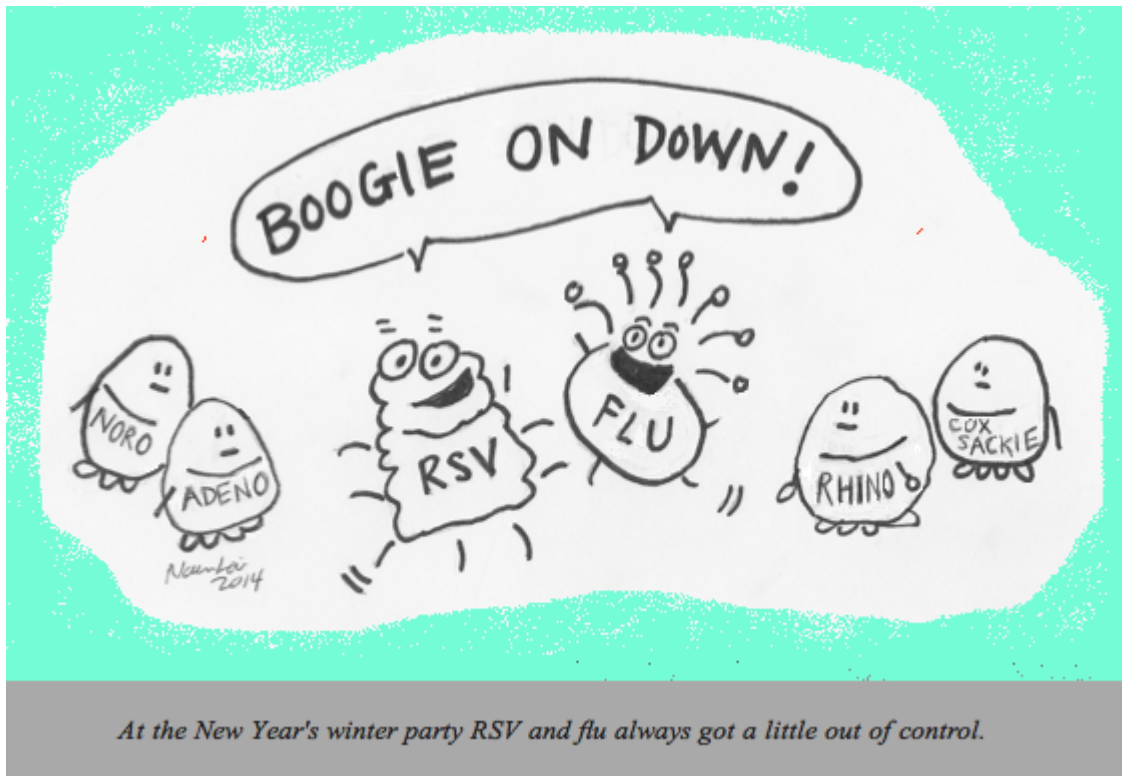
Rewards can, however, be useful occasionally for helping children reach milestones (such as toilet training) or for motivating them to participate in unpleasant activities (such as getting shots at the doctor's office). The key is to avoid using rewards frequently or systematically as a way of managing the regular activities of family life, unless you are getting specific guidance from a professional to do so.

Erica Reischer, Ph.D.

Adapted from WHAT GREAT PARENTS DO: 75 Simple Strategies for Raising Kids Who Thrive by Erica Reischer, Ph.D. © 2016 by Erica Reischer. TarcherPerigee, an imprint of Penguin Random House LLC.

Erica Reischer, Ph.D., is a clinical psychologist and parent educator who leads popular parenting classes and workshops at UCSF Benioff Children's Hospital, Habitot Children's Museum, and the University of California. Her writing about children and families appears in *Psychology Today*, *The New York Times*, *The Washington Post*, and *The Atlantic*.

RSV: nothing to sneeze at!



“A baby in my child’s daycare was hospitalized for RSV,” panicked parents said to us the other day. But RSV (Respiratory Syncytial Virus) is not just a daycare phenomenon. As we are currently experiencing in our office, this virus causes MANY more run-of-the-mill office visits than hospitalizations.

Right now, RSV season is in full swing. RSV is one of the most common causes of the common cold. It is THE most common cause of childhood bronchiolitis (inflamed tiny airways in the lungs), but most of the time RSV causes a really miserable cold without any other complications. Most of us have had RSV many times. RSV tends to be particularly tough on babies and toddlers because the worst episode of RSV is usually the first time you catch the germ.

RSV glues to cells from the nose down to the lungs, causing breathing difficulties. The boogies from RSV tend to be very thick and kids’ lungs goo-up, sometimes causing a wheeze (like that of a person with asthma). The cough from RSV can easily last a month. The disease can be very dangerous in young infants, babies born earlier than 38 weeks (premature), and

babies with chronic lung and heart disease, because of their inability to clear the gunk that RSV produces in their airways. Some kids get fever with RSV and some do not.

Like all cold viruses, no medication kills RSV, so the germ needs to “run its course.” The third through the fifth day of the illness are generally the peak days for symptoms. Here are ways to help your ill child:

- Stay away from the over-the-counter [cough and cold medicines](#)— they can have more side effects than helpful effects.
- If your child is over one year old, [honey can help relieve the cough](#). Try giving 1 teaspoon 3-4 times a day.
- For the little ones who can't (or won't) blow their noses, put a drop or two of nasal saline in each nostril and use a suction device like a bulb syringe to pull out the discharge. Warning: over-zealous bulb suctioning, more than three to four times a day, can be irritating to the nose. Sometimes just the saline alone, without suction, is enough to promote sneezing which will catapult out the mucus.
- Run a cool mist humidifier in her bedroom or sit with your child in a steamy bathroom so water vapor loosens her congestion.
- Give acetaminophen (if over two months of age) or ibuprofen (over six months of age) as needed for fever or discomfort from a clogged head.

Just like you when **you** have a cold, your child may lose her appetite because she has a belly full of post nasal drip and overall feels lousy. Do not fret over her lack of food intake, but do hydrate her well. Breast milk or formula, because of their nutrition, is the best choice for hydrating infants with a cold. For older children, encourage water, but if your child is not eating, make sure there is salt and sugar in her fluids to keep her going. Don't be afraid to [give your child milk](#)

[when she has a cold](#). Good old-fashioned chicken broth is another great source of hydration.

[For kids under two years of age, avoid the use of smelly chest rubs containing menthol or camphor](#) (e.g. Vicks Vapor Rub) and in older children, don't introduce a rub for the first time when your child is ill. When he is sick is a terrible time to discover that a chest rub sends your child into an allergic coughing fit or to discover that he hates the smell.

How do you know if you need to take your child to the doctor? [Read here to help you decide](#). Watch for signs of difficulty breathing: rapid breathing, ribs sticking out each time your child breathes in ([click here](#) for our video example of this), and/or belly moving in and out with each breath, and grunting. A child who is short of breath will be unable to breathe and drink at the same time. A child who is inconsolable with RSV might have additional infections such as pneumonia, ear infections or sinus infections.

Since our immune systems do not make a long-lasting antibody response to RSV, our bodies do not "remember" RSV, and we can catch it again and again. This makes the creation of an RSV vaccine difficult, because vaccines work by boosting our natural defense systems. Vaccines cannot boost an immune response that does not occur naturally.

Take heart, even if your child gets RSV every winter, each episode will usually be less severe than the last. Just look at us pediatricians, we have contracted it so many times, we may sneeze only once before the germ retreats.

Hopefully your family escapes RSV this year! Continue good hand washing and encourage your child to cough into his sleeve to prevent spread of RSV and other Really Sick Viruses.

Naline Lai, MD and Julie Kardos, MD

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How to tell if your baby or toddler has autism



Autism is a communication and socialization disorder. Pediatricians watch for speech delay as a sign of autism. But even before your child is expected to start talking at 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. 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 **two 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 doctor.

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.

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 be convinced that their baby looks over at them in response to their name being called. However, sometimes parents have so many nicknames for their baby that this milestone might be delayed a bit until parents are more consistent with always using the same name to address their child. 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 know 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 ("You're gone, you're back, haha!"). 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 in fact common 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, a desire that autistic children typically fail to demonstrate. It is also normal that at this age children have temper tantrums in response to seemingly small triggers such as being told "no." Unlike in school-age children, difficulties with "anger management" are normal at age one year.

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, rrrrooom!" 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 try periodically 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, a toddler should still be interested in other children.

Many **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 we 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.

Another marker for autism can be **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 and 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 work 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

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modified from the original 2010 and 2013 posts

How to treat a cold



For kids over one year of age, the Honey Bear offers grrr-eat relief

So many children (and their parents) have colds now. Really yucky colds, often accompanied by fever. Take heart that it's not quite flu season- the yearly flu epidemic has not yet fully hit the United States. Are you staring at the medicine display in the pharmacy, wondering which of the many cold medicines on the shelf will best help your ill child? How we wish we had a terrific medication recommendation for how to treat a cold. Unfortunately, we do not. And antibiotics-as powerful as they can be at killing bacteria- do not cure colds, which are caused by viruses.

Watching your child suffer from a cold is tough. But why give something that doesn't help her get better and has potential side effects?

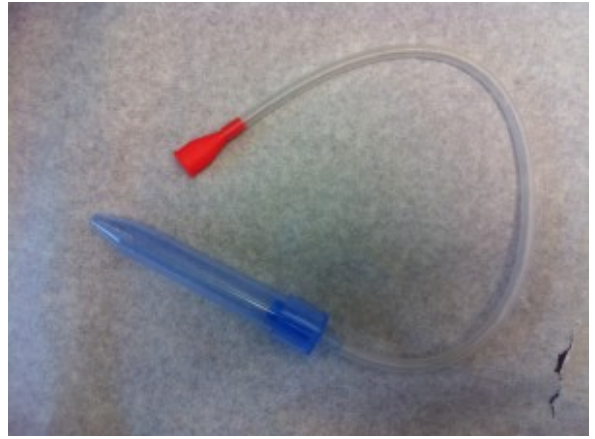
Don't despair, even if you can't kill a cold virus, there are plenty of things you can do to make your child feel better:

- -If she has a sore throat, sore nose, headache, or body aches, consider giving acetaminophen or ibuprofen to treat the discomfort.
- -Give honey for her cough and also to soothe her throat if she is over one year of age.
- -Run a cool mist humidifier in her bedroom, use saline nose spray or washes, have her take a soothing, steamy shower, and teach her how to blow her nose.
- -Break up that mucus by hydrating her well – give her a bit more than she normally drinks.
- -For infants, help them blow their noses by using a bulb suction. However, be careful, over-zealous suctioning can lead to a torn-up nose and an overlying bacterial infection. Use a bulb suction only a few times a day.

The safety and effectiveness of cough and cold medicine to treat a cold has never been fully demonstrated in children.

In fact, in 2007 an advisory panel including American Academy of Pediatrics physicians, Poison Control representatives, and Baltimore Department of Public Health representatives recommended to the U.S. Food and Drug Administration (FDA) to [stop use of cold and cough medications](#) under six years of age.

Thousands of children under twelve years of age go to emergency rooms each year after over dosing on cough and cold medicines according to a 2008 study in [Pediatrics](#) . Having these medicines around the house increases the chances of accidental overdosing. Cold medications do not kill germs and will not help your child get better faster. Between 1985 and 2007, six studies showed [cold medications didn't have significant effect over placebo](#).



The self billed “snot sucker” Nose Frida

So you can ignore the shelf of children’s cough and cold medicine. Instead, buy saline nose drops or spray to help stuffy noses, acetaminophen (Tylenol) or ibuprofen (Motrin, Advil), to treat discomfort, and fluids- and yes, milk is ok during a cold- to prevent dehydration.

Fortunately, when your kids have a cold, unlike you, they can take as many naps as they want.

Naline Lai, MD and Julie Kardos, MD

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updated from our 2011 post

Last Minute Holiday Gifts Ideas

We’re on Happy Healthy Kids!

12 Healthy Gift Ideas

Fever: what's hot, what's not, and what to do about it



Photo by Lexi Logan

Parents ask us about fever more than any other topic, so here is what every parent needs to know:

Fever is a sign of illness. Your body makes a fever in effort to heat up and kill germs **without harming your body.**

Here is what fever is NOT:

- Fever is NOT an illness or disease.
- Fever does NOT cause brain damage.
- Fever does NOT cause your blood to boil.

- Unlike in the movies and popular media, fever is NOT a cause for hysteria or ice baths.
- Fever is NOT a sign of teething.

Here is what fever IS:

- In many medical books, fever is a body temperature equal to or higher than 100.4 degrees Fahrenheit.
- Many pediatricians consider 101 degrees Fahrenheit or higher as the definition of fever once your child is over 2 months of age.
- Fever is a great defense against disease, and thus is a SIGN, or symptom, of an illness.

To understand fever, you need to understand how the immune system works.

Your body encounters a germ, usually in the form of a virus or bacteria, that it perceives to be harmful. Your brain sends a message to your body to HEAT UP, that is, make a fever, to kill the germs. Your body will not get hot enough to harm itself or to cause brain damage. Only if your child is experiencing Heat Stroke (locked in a hot car in July, for example), or if your child already has a specific kind of brain damage or nervous system damage (rare) can your child get hot enough to cause death.

When your body has succeeded in fighting the germ, the fever will go away. A fever reducing agent such as acetaminophen (e.g. Tylenol) or ibuprofen (e.g. Motrin) will decrease temperature temporarily but fever WILL COME BACK if your body still needs to kill off more germs.

Symptoms of fever include: feeling very cold, feeling very hot, suffering from muscle aches, headaches, and/or shaking/shivering. Fever often suppresses appetite, but thirst should remain intact: drinking is very important with a fever.

Fever may be a sign of any illness. Your child may develop fever with cold viruses, the flu, stomach viruses, pneumonia,

sinusitis, meningitis, appendicitis, measles, and countless other illnesses. The trick is knowing how to tell if your child is VERY ill or just having a simple illness with fever.

Here is how to tell if your child is VERY ill with fever vs not very ill:

Any temperature in your newborn infant **younger than 8 weeks old that is 100.4 (rectal temp) degrees or higher** is a fever that **needs immediate attention** by a health care provider, even if your infant appears relatively well.

Any fever that is accompanied by moderate or severe **pain, change in mental state** (thinking), **dehydration** (not drinking enough, not urinating because of not drinking enough), **increased work of breathing/shortness of breath**, or **new rash** is a fever that **NEEDS TO BE EVALUATED** by your child's doctor. In addition, a fever that lasts more than three to five days in a row, even if your child appears well, should prompt you to call your child's health care provider. Recurring fevers should also be evaluated. Additionally, if your child is missing vaccines, call your child's doctor sooner rather than later.

Should you treat fever?

As we explained, fever is an important part of fighting germs. Therefore, we do NOT advocate treating UNLESS the side effects of the fever are causing harm. Reduce fever if it prevents your child from drinking or sleeping, or if body aches or headaches from fever are causing discomfort. If your child is drinking well, resting comfortably or playing, or sleeping soundly, then he is handling his illness just fine and does not need a fever reducing agent just for the sake of lowering the fever.

A note about febrile seizures: Some unlucky children are prone to seizures with sudden temperature elevations. These are called febrile seizures. This tendency often runs in families

and usually occurs between the ages of 6 months to 6 years. Febrile seizures last fewer than two minutes. They usually occur with the first temperature spike of an illness (before parents even realize a fever is present) and while scary to witness, do not cause brain damage. No study has shown that giving preventative fever reducer medicine decreases the risk of having a febrile seizure. As with any first time seizure, your child should be examined by a health care provider, even if you think your child had a simple febrile seizure.

Please see our “How sick is sick?” blog post for further information about how to tell when to call your child’s health care provider for illness.

Julie Kardos, MD and Naline Lai, MD

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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.

"My, the wax just keeps pouring out of your ears"

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

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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 generously 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

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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

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