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?

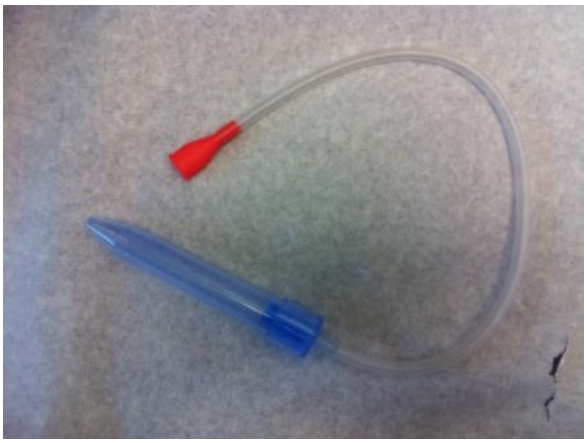
Don't despair, even if you can't kill a cold virus, there are plenty of things you can do to make your child feel better:

- -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 suffy 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

updated from our 2011 post

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 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 i**s 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

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

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: the advanced course

Just when you thought your child graduated from potty training …there's more

Believe it or not, this post is for parents of kids who are already potty trained. Because sometimes even kids who are potty trained will refuse to use the toilet.

Changes and transitions, such as the start of a new

school year, can trigger regression in kids who have been potty trained for years. Now that your children have been back to school for a few weeks take the quiz:

-Does your child come home from school and make **a mad dash for the bathroom** before he even gets his shoes off or asks you for a snack?

-Does your child stop eating and complain of **belly pain after two bites of dinner**?

-Does your child's **poop routinely clog your toilet**?

-Is your child's **underwear sometimes damp**?

-Have you noticed **skid marks** (small streaks or smears of poop) on your child's underwear?

If you answer "yes" to ANY of these questions, then read on.

Advanced Potty Training

The main problem many kids encounter is that once school starts, they have a lot of new distractions and can't be bothered to pee or poop. First, the morning routine might be more rushed. In school, the teacher is teaching. Your kid is interacting with other kids. The school's bathroom is foreign, and may even have an auto-flush toilet: scary for the newly-trained. And unlike your newly potty-trained toddler who often finds it thrilling to try out every public restroom he sees, kids in school may feel more self-conscious, and not as adventurous, about visiting new bathrooms.

School bathrooms can be smelly, loud, and even places where kids bully each other. Some kids develop an aversion to using the school bathroom. These kids hold their pee and poop all day long until they get home, then run into the house and make a mad dash for the bathroom.

A child's internal debate

For a kid who becomes overstimulated at school or who develops an aversion to the school bathroom, his bladder and brain have a conversation that goes like this:

Bladder: I am full.

Brain: Hold it, I don't want to use the bathroom right now.

Bladder: But I REALLY have to pee.

Brain: Tough luck, Bladder, just wait till we get home.

Bladder: But I have no more room for pee!

Brain: Deal with it, Bladder!

So, the bladder has two choices:

1-Bladder overflows, at least enough to relieve a bit of pressure. This causes damp underwear. (For other reasons click here to review our post on damp underwear.)

OR

2-Bladder distends to accommodate more urine and confuses the nerves that supply sensation to the bladder. Kids lose the ability to tell if they have to urinate, which leads to full bladder-emptying accidents, and can lead to urinary tract infections.

A similar discussion can occur between your kid's brain and his rectum:

Rectum: I am full of poop, Brain. Take us to the bathroom.

Brain: In school? Are you kidding? I am enjoying this game the class is playing/I am embarrassed to poop in school/I am afraid of the school bathroom. HOLD IT!

Rectum: OK, but you're not going to like how this comes out in the end.

The rectum also has two choices: release just a bit of stool so it doesn't feel so full and uncomfortable – these are skid marks. OR it will just hold onto the stool, making it larger and harder all the while, so it becomes painful and scary to pass and ultimately clogs the toilet.

This cycle leads to more problems – over time, the distended rectum develops decreased sensation (sound familiar?) and ultimately the child loses the ability to feel when he has to poop. Large poop masses in distended intestines can lead to pain while eating (the kid who eats two bites of dinner, then stops because of belly pain). Poop can leak out without your child knowing because he is unaware of the sensation of the chronically-ignored-full-rectum. In addition, a full rectum will also press on the bladder changing the way the brain is sensing whether or not to void.

How can we parents prevent these problems?

Remind your child to use the bathroom upon waking up in the morning and again before leaving the house for school. Even if he says he does not have to go, tell him to "Just check- sit for 2 minutes."

Ask your child if he uses the bathroom in school. Preschool and early elementary school teachers often have scheduled bathroom breaks, but then it's entirely up to your child to remember to use the bathroom. Encourage him to stop in the bathroom around lunch time in school.

Once home from school, remind your child to use the bathroom or "just check" if he hasn't already done so.

If you leave the house again for an after-school activity, insist that he "just check" again to decrease your chances of having to use another "foreign" toilet.

Incorporate a potty check into your child's bedtime routine, even if he went relatively recently. Ideally the healthy

bladder empties four to six times a day and the healthy bowel easily passes a stool at least once a day or every other day.

Because boys usually stand to urinate, remind them to sit at least once or twice a day, even if they don't feel the urge to poop. As a mom of three boys, trust me: they often surprise themselves.

Even middle school and high school kids can have these problems. Suggest to your older child who, for whatever reason, avoids school bathrooms, that she can stop by the school nurse's office to use the bathroom. She could also get up in the middle of class, if needed, and use the bathroom when it is most likely to be empty of other students, unlike during change-of-class time.

School cafeteria food and snacks provided at sports or other after school activities are not always healthy and can contribute to making stools too hard, so make sure to provide healthy choices at home with plenty of fruits and vegetables. Teach your kids to avoid too many cookies and other high fat foods – these are constipating foods. Encourage water-drinking. Caffeine-containing drinks (ice tea, soda) cause excess urine production and thus more stress on the bladder that your child might already be forcing to "hold it" for too long.

As for the children who frequently run to the bathroom in the daytime, but only pee a tiny bit, beware of something called urinary frequency syndrome.

Final exam

1-Does your child use the bathroom regularly, without stress or pain?

2-Can your child "go with the flow" in school as well as home, without any toilet clogging?

3-At the end of the day, is your child’s underwear without urine or skid marks?

If you can answer YES to all of the above, then you and your child have passed advanced potty training!

Julie Kardos, MD and Naline Lai, MD

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

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!

Julie Kardos, MD and Naline Lai, MD

Pack healthy school lunches: beware of junk food disguised as healthy foods

Junk food in disguise

Need ideas on how to pack healthy school lunches? Beware of junk food masquerading as healthy food. Dr. Roxanne Sukol, an internist who writes the popular nutrition blog Your Health is on Your Plate , mom of three children, and friend of Dr. Kardos's from medical school, shares her insights.

What should we pack in our children's lunch bags?

The key to retraining our children to eat real food is to restore historical patterns of food consumption. My great-grandparents didn't eat potato chips, corn chips, sun chips, or moon chips. They ate a slice of whole-grain rye bread with a generous smear of butter or cream cheese. They didn't eat fruit roll-ups. They ate apricots, peaches, plums, and grapes. Fresh or dried. Depending on where your family originated, you might have eaten a thick slice of Mexican white cheese (queso blanco), or a generous wedge of cheddar cheese, or brie. Sunflower seeds, dried apples, roasted almonds. Peanut butter or almond butter. Small containers of yogurt. Slices of cucumbers, pickles, or peppers. All of

these make good snacks or meals. My mom is proud to have given me slices of Swiss cheese when I was a hungry toddler out for a stroll with my baby brother. Maybe that's how I ended up where I am today.

When my own children were toddlers, I gave them tiny cubes of frozen tofu to grasp and eat. I packed school lunches with variations on the following theme: 1) a sandwich made with whole grain bread, 2) a container of fruit (usually apple slices, orange slices, kiwi slices, berries, or slices of pear), and 3) a small bag of homemade trail mix (usually peanuts + raisins). The sandwich was usually turkey, mayo and lettuce; or sliced Jarlsberg cheese, sliced tomato, and cream cheese; or tuna; or peanut butter, sometimes with thin slices of banana. On Fridays I often included a treat, like a few small chocolates.

Homemade trail mix is one terrific snack.

It can be made with any combination of nuts, seeds, and/or dried fruit, plus bits of dark chocolate if desired. Remember that dark chocolate is good for you (in small amounts). Dried apple slices, apricots, kiwi or banana chips, raisins, and currants are nutritious and delicious, and so are pumpkin seeds and sunflower seeds, especially of course in homes with nut allergies. Trail mix can be simple or involved. Fill and secure baggies with ¼ cup servings, and refrigerate them in a closed container until it's time to make more. I would include grains, like rolled oats, only for children who are active and slender.

What do I consider junk food?

Chips of all kinds, as well as those "100 calorie packs," which are invariably filled with 100 calories of refined carbohydrate (white flour and sugar) in the form of crackers (®Ritz), cereal (®Chex), or cookies (®Chips Ahoy).

You can even find junk food snacks for babies and toddlers

now: The main ingredients in popular Gerber Puffs® are refined flour and sugar. Reviewers tout: “You just peel off the top and pour when you need some pieces of food, then replace the cap and wait for the next feeding opportunity.” **Are we at the zoo**? “He would eat them all day long if I let him.” **This is not a benefit. It means that the product is not nutritious enough to satisfy the child’s hunger.**

A note about drinks

Beware not only of drinks that contain minimal amounts of juice, but also of juice itself. Even 100% fruit juice is simply a concentrated sugar-delivery system. A much better approach is to teach children to drink water when they are thirsty, (See my post entitled **One Step at a Time**) and to snack on fresh fruit when they are hungry. Milk works, too, especially if they are both hungry and thirsty!

Roxanne Sukol, MD

Roxanne B. Sukol, MD is board-certified in Internal Medicine and practices Preventive Medicine in the Wellness Institute at the Cleveland Clinic in Ohio. Dr. Sukol’s nutrition blog Your Health is on Your Plate *celebrates ten years of blogging this summer. Since **her** patients (the grown-ups) are the ones packing the school lunches for **our** patients, we thank her for this post.*

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Reviewed 2019