

Pediatrics ^{& of} Parents

The newsletter for people who care for children

Richard J. Sagall, MD, Editor

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Cough Medicine Dangers

Nearly 7,100 children under 12 years old are seen in emergency departments each year for problems related to over-the-counter and prescription cough and cold medications. Two-thirds of the visits were due to unsupervised ingestions. Only 47% of ingestions of other medications are unsupervised.

These medications contain decongestants, antihistamines, antitussives (cough suppressant), and/or expectorants. There is now great doubt as to the effectiveness of many of these classes of drugs. Not only are these medications largely ineffective, but they can be dangerous if taken in large amounts. There's little reason to have them in your home.

Many manufacturers of these medications are voluntarily adding child-resistant packaging to their cough and cold medications. According to Linda Suydam, president of the Consumer Healthcare Products Association, "Our companies are all committed to the idea of child-resistant packaging, and most products already have that, and we are now working very quickly to make sure all products do."

Pediatrics, 4/08 and *Family Practice News*, 2/15/08

Chickenpox Complications

Most people think of chickenpox – caused by the varicella zoster virus – as a benign childhood illness that, though annoying and uncomfortable, is no more severe than a bad cold. But that's not the case. Chickenpox can cause severe illness and even death. That's why all children should receive the chickenpox vaccine.

To determine just how serious a chickenpox infection can be, researchers in the United Kingdom evaluated all the cases of chickenpox requiring hospitalization during a 13-month period. To be counted, the sick child had to be under 16 years old. They found 112 children ranging in age from three to fourteen years old. This calculates to slightly less than one child out of every 100,000 being hospitalized due to complications of chickenpox.

These children experienced a number of potentially life-threatening chickenpox-related complications:

- Bacteremia/septic shock – 30 children

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Chickenpox – Continue from page 1

- Pneumonia – 30 children
- Encephalitis (inflammation of the brain) – 26 children
- Ataxia (balance problems) – 25 children
- Toxic shock syndrome – 14 children
- Necrotizing fasciitis (severe infection of the skin leading to skin death) – 7 children
- Disseminated coagulopathy (problems with blood clotting) – 5 children
- Fulminant varicella (a severe case of chickenpox) – 5 children
- Neonatal varicella (chickenpox in newborns) – 3 children

(The total is greater than 112 because some children had more than one complication.)

The average length of hospitalization was seven days, with stays ranging between one and sixty-eight days. Forty-one children had problems when discharged, the most common being ataxia and skin scarring. Of the 112 children, six died (one death was intrauterine and four of the other five children had a pre-existing medical problem such as heart disease, asthma, etc.).

Most of the complications occurred in otherwise healthy children. The authors conclude that, “Most complications, excluding deaths, occur in otherwise healthy children and thus would be preventable only through a universal childhood immunization program.”

Allergen of the Year

Time magazine has its person of the year and the American Contact Dermatitis Society (ACDS) has its contact allergen of the year. This year the winner is nickel. According to the ACDS, nickel is a significant cause of contact dermatitis, and the number of people, especially children, with nickel sensitization is rising.

According to Kathryn A. Zug, MD, a dermatologist at the Dartmouth Hitchcock Medical Center, “To dismiss nickel’s importance and relevance to public health and skin disease would be a mistake.” The metal is found in many places – coins, jewelry, buckles, pant snaps, tools, and other products. It’s also in many foods – legumes, nuts, grains, chocolate, and fish. It’s also in many medicines and vitamins.

The number of patients whose skin tested positive for nickel rose from 11% in 1985-1990 to 19% in

2003-2004. Of 391 children skin tested from 2001 to 2004, 28% tested positive for nickel. The most common problem is a rash in the area of nickel contact. The rash frequently appears on the abdomen just below the navel and is caused by the nickel found in pants buttons.

The best approach to dealing with nickel sensitivity is to find ways to lessen sensitization. Removing nickel from consumer products is difficult to do, so the next best thing is to avoid products known to contain nickel, such as belt buckles, jeans snaps, and earrings.

Family Practice News, 2/15/08

TV Watching and Social Skills

The American Academy of Pediatrics (AAP) recommends children over two years old watch no more than two hours of television per day and not have a TV in their rooms. But what happens to kids who watch more than the recommended amount?

A recent study examined this by looking at the amount of television children watched at two ages – two and a half and five and a half years old. The behavior of all the children was evaluated using standardized tests.

Sixteen percent of parents said their two year olds watch more than two hours of TV per day, 15% said their five year olds watched more than two hours per day, and 20% said their children watched more than two hours at both ages. Forty-one percent of the five year olds had a TV in their bedrooms.

There was no relationship between the amount of television watched as a two year old and behavioral problems at age five. Children with a television in their bedrooms had more sleep problems and less emotional reactivity than children without a TV. Having a TV in the bedroom had no effect on social skills. The five year olds who watched more than two hours of TV had fewer social skills than the kids who watched less TV.

This study supports the AAP recommendations – no TV in the child’s room and the less TV watched the better. The good news is that excessive early TV watching doesn’t have long-term detrimental effects on a child’s social skills.

Pediatrics, 10/07

To Bank or Not to Bank, That is the Question

By Vikki Sloviter

What kind of stroller should we buy? How do we find a good pediatrician? Should we circumcise? New parents' questions are endless. And, as if they don't have enough issues to consider, both first-time and seasoned parents have another one: should we bank our baby's cord blood?

What is Cord Blood?

Umbilical cord blood is found in the umbilicus and placenta of newborn babies. In the not too distant past, umbilical cord blood and the placenta were discarded as medical waste; there was no apparent use for them. But we now know that umbilical cord blood contains stem cells – the genesis of all the body's cells – that have the potential to treat or cure a variety of blood or immune diseases.

Three types of stem cells are found in mammals, including humans: embryonic stem cells, umbilical cord stem cells, and adult stem cells. Embryonic stem cells, which have been the focus of a nationwide ethical debate, are not the same as cord blood stem cells. Embryonic stem cells come from a developing embryo, whereas cord stem cells come from a newborn's umbilical cord; fetus viability is not an issue with umbilical cord stem cells.

How Do Stem Cells Help Cure Cancer?

If you've ever known or heard of someone who received a bone marrow transplant to help cure his cancer, it was because bone marrow contains hematopoietic (blood-forming) stem cells that regenerate and become more hematopoietic stem cells. Or, they can become white blood cells, red blood cells and platelets – three types of blood cells that fight off infection, carry oxygen throughout the body and help fight infection. A cancer patient who has had chemotherapy treatment, for example, has a compromised immune system – his body's cells can no longer keep him healthy and fight off disease – because his bone marrow has been weakened by chemotherapy. If he receives donor bone marrow that contains hematopoietic stem cells, his system might be able to renew those cells, which will become white cells, red cells, platelets, and additional hematopoietic cells and he'll be able to combat the disease and become healthy again.

Bone marrow and peripheral blood stem cells have been the primary sources of hematopoietic stem cells

for transplants, but the donor and the recipient have to have almost identical tissue types (human leucocyte antigen (HLA) match). And, there has always been a considerable chance that the recipient's body will reject the transplanted cells (graft-versus-host disease), even from siblings, who provide the best chance for perfect HLA match.

If Bone Marrow Contains Stem Cells, Why Use Cord Blood for Transplants?

Bone marrow transplants can be successful, but there are risks. A patient needs to find a donor with the identical or closely matched tissue type (a process that can take many months), the donor needs to undergo a surgical procedure to remove the marrow, and the patient's body may reject the marrow.

Umbilical cord blood provides several advantages over bone marrow. Since there are millions of births a year, there is virtually an unlimited resource of stem cells. And, the procedure to remove the stem cells is painless, since the cells are removed from the umbilical cord, which has no sensation. Donating bone marrow, on the other hand, is a surgical procedure that can be painful for the donor. Also, the HLA match requirement between cord blood donor and recipient does not have to be as closely matched as with bone marrow. (With bone marrow transplants, the donor and recipient must have five of six matching HLAs, whereas cord blood transplants need four of six matching HLAs). This means there are more potential donors and the waiting time may be shorter. Another advantage of cord blood transplantation is the lower incidence of graft-versus-host disease, which means the patient is less likely to reject the stem cells.

Private Cord Blood Banks

The medical and scientific communities agree that cord blood banking can help save lives. Just as donated bone marrow can help save a patient's life, donated stem cells from cord blood can help save someone's life.

Cord blood banking is the act of storing cord blood for future stem cell transplant use. Many private blood banks have jumped at the chance to sell a kind of "biological insurance" to parents who think they may need cord blood one day to cure their child's cancer or the cancer of one of their other children. But, private cord blood banking is expensive. The initial fees, which in-

clude enrollment, processing, banking, overnight courier and first year of storage, can cost almost \$2,000. Then, most companies recommend that families store their child's cord blood for 18 years, until their child has the legal right not to store the blood anymore. At \$125 per year for 17 years, that's \$2125. So, for more than \$4000, a family can bank its child's cord blood. For most families, private cord blood banking is simply not an option.

Public Donation for the Public Good

Many doctors object to the idea of private cord blood banking because they think these companies take advantage of parents' insecurities and concerns during an emotional time. Cord Blood Registry, one of the largest and most widely-recognized private cord blood banks in the United States, advertises that cord blood banking is a "once-in-a-lifetime opportunity – only at birth." The company states that parents can choose to donate their baby's cord blood for public use, but that their children or other family members would benefit from private blood banking since the blood might be more compatible than a donor's, and it would be available immediately.

Doctors take issue not only with the nature of private cord blood banks' advertising (preying on vulnerable families), but also with their science as well. A 1998 study published in the medical journal *Nature Medicine* found that some pediatric leukemias may exist in utero, which means that the hematopoietic stem cells contained DNA mutations that were possible precursors to leukemia. This means that the stored stem cells from a leukemia patient would not be able to be used on that patient.

Such research contradicts many private blood banks' claims that a child's stem cells can be used to treat her own cancer. (However, the private blood bank, CorCell, may have reason to celebrate since last year *Pediatrics* published a study of the first successful autologous use (a patient using her own cells) of transplanted cord blood stem cells—which were stored by CorCell—in a three-year-old girl with leukemia).

Ultimately, the approximate 25 national private blood banks like Cord Blood Registry, Viacord and CorCell are for-profit ventures whose goal is to make money. Public cord blood banks, on the otherhand, offer free donation and storage to eligible donors. Many blood banks and hospitals are affiliated with the National Marrow Donor Program®, a government-funded organization that coordinates more than 500 marrow and cord blood donation facilities around the country and hosts a registry of patients and donors. Opened in

1992, New York Blood Center's National Cord Blood Program is the oldest nonprofit public cord blood program in the world and collects more than 5,000 cord blood units per year.

Donating to a public cord blood bank requires that the donor meet certain criteria (private cord blood banks do not screen as strictly), which include that the donor be at least age 18 and not have a history of HIV/AIDS, cancer, diabetes, hepatitis or malaria.

Aside from the costs, the primary difference between private and public donation is that private donation means you pay a premium for access to your own child's stem cells, whereas public donation means you donate your child's stem cells for the public good. In many cases, public donors may not have access to their child's donated cells, even if they need them in the future.

So Should I Bank My Baby's Cord Blood?

When asked, doctors usually recommend that if parents want to store their child's cord blood they do so with non-profit organizations that store blood for public use. And the American Academy of Pediatrics also advises against private banking. Some doctors assert that the only case in which private donation may be warranted is when a family member has a current or near potential need for a stem cell transplant. Even in such cases, however, there is only a 25% chance that a sibling will be a perfect match.

Not only is public donation free, but also it's low risk. There are no costs associated with donating cord blood, and the known likelihood of ever needing a cord blood transplant ranges from 1 in 1000 to 1 in 200,000. So with public donation, families don't shell out thousands of dollars for a service they will probably – and hopefully – never need.

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Lyme Disease

Incidence of Lyme disease in children (2003-2005)

0-4 yrs old	3,238
5-9	6559
10-14	5649
15-19	3727

Centers for Disease Control and Prevention

Children's Physical Activity and Cardiovascular Risk: Implications for Physical Activity Guidelines

By Lars Bo Anderson, PhD

Atherosclerosis (hardening of the arteries) begins early in childhood. Because cardiovascular disease (CVD) risk factors do not cause disease in children, parents don't tend to focus on this health issue. However, a child with a higher CVD risk factor is likely to become an adult with high risk factor. And, even if a child has a high level in a single risk factor, risk factors tend to follow each other and result in elevated levels in many risk factors in the same child. This phenomenon is called 'clustering' and happens because obesity and physical inactivity cause insulin resistance.

Insulin is a hormone responsible for regulating blood sugar, but it also deposits fat in fat cells and influences cholesterol and blood pressure levels. Physical activity (PA) may positively affect the atherosclerotic process through a number of mechanisms, and clustering of risk factors is related to physical inactivity through some of the same mechanisms as fatness.

In 1988 the American College of Sports Medicine recommended that children exercise vigorously for at least 20-30 minutes per day. Then in 1998, the UK Health Education Authority revised the recommendation to at least one hour per day, adding that if children exercised one hour at least twice a week, their muscular strength, flexibility and bone health would improve. These guidelines were mainly based on studies using quite crude measures of exposure (subjective measures of PA) and outcome (mainly single CVD risk factors).

For our study, we derived guidelines based on the analysis of associations of objectively measured PA with clustering of cardiovascular disease (CVD) risk factors in children. Objectively measured PA has the advantage that it is possible to measure the amount of everyday activities such as walking and free play, and clustering of risk factors is a condition that is a much stronger indicator of the child's health than single risk factors. Few parents and doctors know that about 15% of children from the age of nine years have a risk factor profile where many risk factors are elevated, and that physical inactivity, obesity or both cause the clustering.

We used data from 1,732 randomly selected nine- and 15-year-old school children from Denmark, Estonia and Portugal who had participated in a previous

European Youth Heart Study. Using systolic blood pressure, triglyceride, total cholesterol/high density lipoprotein (HDL), insulin resistance (HOMA), sum of four skinfolds, and aerobic fitness as risk factors, we constructed a composite risk factor score. Subjects having a risk score above one standard deviation (16% of the children with the worst profile) of the composite variable were defined to be "at risk." To measure physical activity, the children wore an accelerometer, a small instrument worn on the hip that measures vertical body movement, for four consecutive days (two weekdays and two weekend days) that measured their activity in counts per minute (cpm).

Our results found that the 20% least-active children had more than three times the risk of cardiovascular disease than the most active children. And, the first to the third quintiles of PA had elevated risk in all analyses. The average time spent in physical activity above 2000 cpm, which corresponds to walking at 2.5 mph, in the fourth quintile was 116 minutes each day in nine year olds and 88 minutes each day in 15 year olds.

Current guidelines of at least one hour per day of physical activity of at least moderate intensity may be an underestimation of the activity necessary to prevent clustering of CVD risk factors in children. Our study found that to prevent insulin resistance – a contributing factor in clustering of cardiovascular disease risk factors – we think children may need to engage in at least 90 minutes per day of daily activity.

Therefore, it is important that children accumulate activity through everyday tasks such as walking to school instead of being driven (in Denmark, where bicycles are a common mode of transportation, we noticed a 10% increase in fitness in children who cycled to school), playing with their mates outdoors instead of sitting in front of the TV, and of course participating in some kind of sports.

Dr. Anderson is a professor in physical activity and health at the Norwegian School of Sport Sciences. He has a PhD in zoophysiology and a second one in medicine. His work is in the effect of physical activity on metabolic disorders in children including obesity and other CVD risk factors.



Children in Hospitals

By John E. Monaco, MD

Pregnant Teens - Who Cares for Them?

It has happened since the dawn of time. Once girls reach puberty and are biologically able to conceive, a certain number of them are going to, no matter what. What has changed over time are the social norms. At times during the history of civilization, it has been acceptable to be a mother at 14, and in many parts of the world it still is. However, in America at the dawn of the 21st century, it is not only socially unacceptable for teenage girls to become pregnant and give birth, but it is in fact quite dangerous, and in ways you might not suspect.

Our hospital is a general community hospital, which means that we admit and care for patients of all ages, and with most medical problems. Our team runs the pediatric unit, which accepts all children between the ages of birth and 18 years. This seems like a fairly straight-forward rule until you consider some of the things that can happen to teens, many of which could easily fall into the "adult" category. One of these, of course, is pregnancy. One reads in the press that the teen pregnancy rate is dropping, yet these statistics are thrown out the window when a 15- or 16-year-old girl who is several months pregnant comes into the Emergency Department (ED) with an asthma attack or appendicitis. For that girl, and for those who need to care for her, the teen pregnancy problem is not only very real, it is immediate and potentially life threatening.

The problem is that no one is willing to claim these "children having children" as their "own." By this I mean the ED staff are obliged to, and willingly do, take care of every patient that comes through their doors. The problem arises when the staff must then find a medical department to care for the child after she has been admitted. Let's take a pregnant girl with appendicitis, which was an actual case in our facility not long ago.

She was 16 and not quite half way through her pregnancy. She presented to the ER with abdominal pain which, of course, everyone assumed was the onset of premature labor. When the OB nurses, who reluctantly came down to the ER, determined that she was not

in labor and the fetus was fine, medical staff further investigated to determine what was causing her pain. CT scans and X-rays could not be done because of the radiation risk to the developing fetus. Therefore, one of our skilled and experienced general surgeons was called to evaluate the patient.

At first he was reluctant, saying that as a pregnant teen she should be cared for by the high-risk OB specialist. The OB folks stated that since she was under 20 weeks gestation, the pregnancy issue was immaterial. The default position, as always, was to call the pediatricians. In general hospitals, the age criterion always seems to win out over all others.

The pediatrician on call was completely unwilling to admit the patient because she was pregnant. And even if the OB service considered the fetus not yet viable, the pediatrician worried about the liability of caring for a child whose baby might be born prematurely or even still born because of another medical issue that involved him. The surgeons stated that if it was appendicitis, which they strongly considered clinically, they would be willing to remove the appendix if the pediatricians could care for the child post-op. The pediatrician was willing to do this but only with the assistance of the OB doctor. Again the OB doctor stated his role was not necessary since the fetus was nonviable. Round and round we went.

The issue was further complicated after the appendectomy, and the pregnant child needed a place to go post-op. Nursing service thought she should go to pediatrics because she was under 18. Pediatric nurses thought it was completely inappropriate to have a pregnant teen on the ward with impressionable toddlers and tweens. Ob/gyn did not want her on their floor because she was more of a typical med/surg patient. The conundrum continued.

Eventually the child received the care she needed and we were able to find a quiet med/surg bed for her where the pediatrician, as well as the OB doctor, could consult. The nurses were happy with this arrangement with a few exceptions.

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Ask "Baby Doc" Eden

By Alvin N. Eden, MD

Antibiotics

"My 21-month-old boy is always sick with fever and one cold after another. His doctor usually does not prescribe an antibiotic. Is our pediatrician doing the right thing?"

You bet he is. It appears that you have a fine pediatrician. First of all, it is not uncommon for toddlers to catch frequent upper respiratory infections as they are around more and more people – babysitters, day care, during trips to the supermarket, etc. The more exposures, the greater the chances of a little child picking up an infection, usually of the respiratory tract. Many of these infections are associated with fever.

Let me explain both the important role antibiotics play as well as the dangers of their over-use and indiscriminate use. Before the age of antibiotics there was little that could be done to treat many dangerous bacterial infections. Epidemics were common. Children became seriously ill and many died. We are now fortunate to have at our disposal many safe and powerful antibiotics that are highly effective and often lifesaving, but they must be used sensibly.

You must remember that antibiotics do not work against viral infections, but are only effective against bacterial infections. And in fact, almost all the respiratory infections infants and toddlers catch are caused by one virus or another. The fever associated with many of these infections should be treated with lots of fluids and sometimes with a fever-reducing medication such as Tylenol or Advil (but never aspirin) and not with an antibiotic.

I can almost hear you saying, "But Dr. Eden, even if my child's illness is caused by a virus, why not put him on an antibiotic just to be on the safe side. It can't do him any harm and it may do some good."

You are wrong. The antibiotic can do him harm and does absolutely no good. Let me explain why.

The first reason is that each and every time an antibiotic is used it increases the chances of your child

developing an allergic reaction to it. When this happens that particular antibiotic cannot be used in the future when it really might be needed.

In addition, an allergic reaction to an antibiotic may eliminate from use many other antibiotics in the same class. For example, a child who develops an allergy to penicillin will often also be allergic to amoxicillin, the bubblegum-tasting antibiotic so popular with kids because of its good taste.

The second reason for not using an antibiotic unless it is really necessary is an even more important one. Bacteria are not stupid. If an antibiotic is used too often it leads to bacterial resistance. This means that a specific strain or type of bacteria builds up more and more immunity to the particular antibiotic each time it is exposed to that antibiotic until it finally becomes completely immune to it. Because of the over-use of antibiotics we are already dealing with some of these smart, drug-resistant "super-bugs." The staphylococcus bacterium is a very good example of this. Fewer and fewer antibiotics are now effective against this life-threatening "super-bug."

There are now some infectious disease specialists who are predicting that if we continue the current over use and indiscriminate use of antibiotics more and more "super-bugs," resistant to any and all antibiotics, will develop. Therefore, further down the road, we may be back to where we started before we had any antibiotics at all to fight many serious bacterial infections.

So what's the bottom line? Your child's doctor should be the only one to decide if an antibiotic is necessary. Please remember that the great majority of early childhood illnesses with fever are caused by one of many types of viruses — not bacteria — and so an antibiotic is rarely indicated. If your child's doctor does prescribe an antibiotic make certain you give the correct dose on time and for the number of days prescribed. Any medication left over in the bottle should be discarded.

When I started practicing pediatrics many years ago, parents would ask me, "Aren't you going to give my

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Perspectives on Parenting

By Michael K. Meyerhoff, EdD

(Over)Protecting Your Children

I am sure you are all aware of the shooting spree that took place at Northern Illinois University, which happens to be one of the universities at which I teach courses on child development and educational psychology. Although my classes take place at off-campus sites, my students and I are obviously affected by the actions of the gunman who killed five people and wounded many others before taking his own life. And the emotional turmoil is even greater when one realizes that this event is simply a magnification and an intensification of what we all experienced after similar events at Virginia Tech and other institutions in recent months.

In the aftermath of the incident, there certainly is no shortage of reasons to be shocked, alarmed, and saddened. However, while I feel enormous sympathy for all the individuals and their family members affected by this tragedy, I am also disturbed by reports that many parents are now in the process of withdrawing their children from the university. Perhaps their reaction is merely the result of an immediate but temporary sense of panic and they either will not follow through or will reverse their decision at some later date. But if parents do prevent their sons and daughters from returning to campus, I believe that will be an even deeper tragedy than the one that has already taken place.

I don't believe the passionate desire of these parents to protect their children is improper. But in my opinion, it is misplaced. While it is the duty of parents to protect their children from harm at earlier stages of development, there comes a point where their primary duty is to protect them from fear.

Let's go back to the beginning of life. For the first few months, the infant is a totally helpless creature. She is dependent on those around her for her very survival and must count on others to take care of her every need. But toward the end of the first year she starts to become more independent. Now she is capable of getting around on her own, and she is highly inclined to start exploring and investigating the world in which she lives. Unfortunately, that world is filled with dangers. There are stairs down which she can tumble, poisonous

substances under the sink she can ingest, small objects upon which she can choke. The potential dangers are endless.

Her parents can protect her by keeping her in their presence whenever they can, and by keeping her restricted to a safe place such as a playpen when they must leave her for a short period of time. However, while these forms of protection will significantly reduce the risk of physical harm, they will cause severe psychological damage as she will never develop the sense of autonomy that is a critical component of a healthy personality. She will also never have the opportunity to develop the skills that will eventually ensure her survival when she must inevitably move beyond her parents' constant presence and control.

The solution is to safety-proof the home as much as possible and then let her go. Obviously, this is not without risk. Even if her parents do a thorough job, there is always a chance that the newly crawling infant will find something they missed, and a steady stream of bumps, bruises, and other minor mishaps is unavoidable. But her parents must realize that their role is no longer that of omnipresent protector. It is now that of a secure base to which she can return for comfort and assistance should she run into trouble as she gradually learns to take care of herself.

This is an incredibly difficult transition for many parents to make. When they watch the news and see a report of an infant being severely injured or killed in some kind of freak household accident, they have to fight the urge to return to the role they played during those first months. But if they want to produce a child who will ultimately make the most of her potential and take full advantage of all the good things the world has to offer, they must take every responsible and reasonable precaution then encourage her to sally forth and hope that whatever harm she suffers will be educational rather than debilitating or fatal.

As the child grows and her world expands, this letting go becomes increasingly difficult. Watching her walk to school for the first time, taking the car for a spin with

her new driver's license or going off on a first date are all events that instill paralyzing fear into parents' hearts. But if they fail to stay strong and succumb to it, and if they consequently restrict rather than confidently encourage, they will produce a child who will be similarly paralyzed by fear and who will never experience the exhilaration and satisfaction that comes with conquering fear and striving to ensure that life's negatives never get in the way of enjoying life's positives.

When watching the news, it is easy to conclude that the world has become a pretty scary place. But if you think about it, the world has always been a pretty scary place. Yes, we have many dangers today that we didn't have yesterday. On the other hand, there were many dangers around yesterday that no longer exist today. I remember when some parents refused to let their children play with other children for fear of contracting polio. And the odds of a child dying of polio back then were considerably greater than the odds of a child dying in a random shooting today.

I recall that I was scheduled to make an out-of-town presentation just one week after 9/11. Since I had to take an airline flight, many of my colleagues, friends, and family members told me I would be crazy not to cancel. Reluctant to do so, I called my secure base – my mother – for counsel. This is a woman whose contemporaries escaped pogroms, survived the holocaust, battled a host of infectious diseases before inoculations and antibiotics eliminated them or rendered them quite harmless, and repeatedly went through childbirth when the survival of the mother was far from a sure thing.

I will never forget my mother's response when I told her I intended to follow through on my plans. While I could detect some consternation and concern in her voice, she calmly replied, "Good for you. Don't let the bastards keep you down."

So to the parents of the surviving Northern Illinois University students, and to all parents who must watch their children leave the safety of their sides, I would say that you are eminently entitled to your worries, but you must strive to fulfill your true parental responsibility. At this point, that responsibility is not to protect your children from harm, which is as impossible as it is inappropriate, but rather to protect them from fear.

Michael K. Meyerhoff, EdD, is executive director of The Epicenter Inc., "The Education for Parenthood Information Center," a family advisory and advocacy agency located in Lindenhurst, Illinois. He may be contacted via e-mail at epicentrinc@aol.com. Send him your suggestions for topics.

Pregnant Teens – Continued from page 6

The point is that there could have been serious delays in care simply because of the arguments over where the child should be treated and to which department she belonged. Teenage pregnancy is not a problem any of us like to deal with or accept. It lends itself to needless moralizing and judgments, not to mention defensive medicine and shifting liabilities. We must not lose sight of the fact that these young ladies "in trouble" are still patients with needs, and further, they will soon be mothers responsible for a new generation of our patients.

John E. Monaco, MD, is board certified in both pediatrics and pediatric critical care. His new book, Moondance to Eternity, is now available. He lives and works in Tampa, Florida. He welcomes your comments, suggestions, and thoughts on his observations.

Antibiotic – Continued from page 7

child a shot of penicillin?" Nowadays the question is "Will you prescribe the bubble gum antibiotic?" My answer in most cases has always been the same, "No, I am not. It is not necessary, it won't work, and it can do a lot more harm than good."

Dr. Eden is the chairman of the Department of Pediatrics, Wyckoff Heights Medical Center, Brooklyn, New York and a clinical professor of pediatrics, Weill Cornell Medical Center, New York, NY. His latest book, Positive Parenting, is now available.

Shampoo Dangers

Using baby shampoos and lotion may expose your child to phthalates, a potentially harmful man-made chemical that is used to soften plastic and stabilize fragrances in cosmetics. Babies exposed to these products have up to five times higher levels of three different phthalate metabolites than babies without such an exposure. However, the urine of babies with no exposure still had measurable levels of at least one phthalate metabolite.

According to Sheela Sathyanarayana, MD, MPH, of the University of Washington, the long-term health effects of phthalate exposure are not known. However, she emphasizes that no one needs to use products that contain this ingredient. The problem is that it may be difficult to know if a product contains phthalates since the FDA doesn't require listing individual components of fragrances.

Pediatrics, 2/08



Children's Emergencies

By Martin Belson, MD

When to go to the Hospital and How to Prepare

Being a parent myself, I can appreciate how one feels when his child has an injury or comes down with an illness. It can be a helpless feeling to see

your child not acting himself or experiencing pain. In addition, many questions go through our heads during these stressful moments including:

- 1) Should I call my pediatrician?
- 2) Should I take my child to the Emergency Department (ED)?
- 3) Should I call the Poison Center?

Also, if you do bring your child to the ED, what can you expect on arrival and during the ED stay? Although this can be a stressful time for parents and children, the ED visit doesn't have to be as agonizing as you might think. The following information offers a few helpful tips for anxious parents and may help answer some of these common questions that arise.

When should you call your pediatrician and prepare to go to the ED? The following is a list of serious or life-threatening emergencies your child could experience for which you should make that call or go directly to an ED. Note: This is not a complete list of all serious or life-threatening emergencies.

- seizures
- decrease in level of consciousness
- sudden dizziness, weakness or change in vision
- extreme lethargy or irritability
- stiff neck and fever
- breathing problems or turning blue
- heavy bleeding
- possible broken bones (fractures)
- head, neck or back injury
- burns of all types, especially on the hands and face
- severe or persisting pain (e.g., abdominal pain)
- continuous vomiting or diarrhea with dehydration
- bloody vomiting or diarrhea
- severe allergic reaction (e.g., swollen lips or tongue)
- petechial rash (small, flat, purple spots that don't disappear when pressure is applied to the skin)

For a possible or known poisoning, call 1-800-222-1222 to connect to the nearest Poison Control Center. Specialists in Poison Information who answer the phones at the Poison Control Center can provide treatment recommendations for a variety of questions concerning:

- Treatment for accidental or intentional poisoning
- Bites (e.g., spiders, snakes, dogs)
- Stings (e.g. bees)
- Food poisoning
- Plant exposures
- Drugs of abuse

Should I Take My Child to a Children's Hospital?

Know where the closest pediatric ED is located in relation to your home, before you need to go there for an emergency. These centers are child-focused, have child-appropriate equipment and are staffed with doctors and nurses trained in pediatric care. Obviously, if your child is in severe distress or there is no pediatric ED within reasonable driving distance, you may just need to take him to the nearest hospital to be stabilized.

When Might it Not be Necessary to Take My Child Directly to the ED?

In general, unless directed to do so by your pediatrician, you may not need to take your child to an ED right away for the following:

- ear pain
- sore throat
- flu-like symptoms
- colds
- nausea
- stomach pain that resolves shortly
- mild, non-bloody vomiting or diarrhea with no signs of dehydration
- minor sprains
- minor headaches
- fever

There are many factors that must be considered by your doctor when deciding when to recommend that your child go to the ED for evaluation of fever, including:

- fever temperature
- length of time child has had fever
- child's age

- child's immunity status (e.g., sickle cell disease)
- any signs of dehydration
- Most importantly: How your child looks

What is the Best Way to Plan for an ED Visit?

Being prepared means more than just keeping emergency numbers by the phone. There are many things parents can do in advance to prevent accidents and injuries, or at least be prepared when they occur. The following suggestions should come in handy and make a stressful situation just a little bit less stressful:

- Know what led up to the emergency: If you weren't there when an injury happened, find out who was and get the details.
- Have a list of your child's full medical history available including: medications, allergies, immunizations, any chronic or recurrent conditions (e.g., asthma), and any surgeries.
- Do remember to bring certain items including: an extra diaper, a favorite stuffed animal, toy or blanket, and some books to read while passing time.
- Check to see if your insurance plan is accepted at the hospital you would go to in case of emergency. If your preferred hospital will not accept your plan, review other options with your company's benefits officer.
- If your child is going to be in the care of another relative, babysitter, or at school or other activities, make sure all of these have the above information and a Consent to Treat Form that authorizes treatment in your absence. Free Consent to Treat and Emergency Information forms can be printed from <http://www.footworkpub.com/erconsent.html>.

What Can My Family Expect During an ED Visit for Our Child?

Here are the basics of what you can expect during your ED visit, including your child's initial evaluation by the nursing staff.

Triage

Your child's initial evaluation will be made by the nursing staff. They will gather information from you about your child including what health problem(s) your child has been having, any medications he or she is taking, and any important past medical history. Your child's vital signs will be taken, including his heart rate, respiratory rate (breaths taken per minute), blood pressure and temperature. In some cases, your child's oxygen level will be checked.

Keep in mind that based on the triage process, other children might need more immediate attention; therefore, be as patient as possible. However, if during your wait, you feel that your child's condition has worsened

then notify the triage nurse immediately.

Doctor's Evaluation

The doctor will first ask you questions about your child's illness or injury followed by an examination of your child. A plan of care will then be started, if necessary, which may include:

- laboratory work (e.g. blood, urine)
- x-rays (e.g., to look at bones)
- medications (e.g. antibiotics)
- intravenous (IV) fluids (e.g. to treat for dehydration)
- wound cleaning and stitches
- breathing treatments for asthma or croup

In some cases the ED doctor will need to discuss your child's condition with a specialist (e.g. surgeon) or have the specialist see your child in person. If the doctor believes it is in your child's best interest to stay in the hospital, your child will be admitted upstairs to be cared for by either your own pediatrician or a doctor on the hospital staff. Otherwise the doctor will give you follow-up instructions for addressing the illness at home.

Be sure not to feed your child during the ED visit until told to do so. If your child will need to be sedated, including for surgery, it is important that he has an empty stomach.

Before Signing Out

Make sure you have a copy of your discharge instructions with any prescriptions. If the discharge instructions are unclear ask for another explanation.

Helpful Hints for a Smooth ED Visit

1. Try to stay calm – Easier said than done but important for all who are involved, especially your child who will pick up on upset parents and become even more frightened.
2. Stay as patient as possible – In a pediatric ED, afterschool, weeknights and weekends are the busiest times. If you go into the situation thinking it might take some time and then leave rather quickly, you will be pleasantly surprised.
3. Stay with your child as much as possible – Many children will want their parents at their side during a procedure or treatments. Ask if you can stay, but for certain procedures, such as a spinal tap, you may be asked to step out of the room for a moment.
4. Reassure your child – Try to reassure your child as much as possible and be truthful. Try not to

Continued of page 16

Children and Pets

By Sandra Lefebvre, DVM

Children and pets – the two seem to be ideal companions. In fact, research has shown that children from pet-owning families have higher levels of self-esteem, social competence and non-verbal communication compared to pet-free households. However, some other evidence suggests that certain types of pets are often associated with childhood illnesses, some of which can be quite severe. Certain species are also more likely to cause physical injury. The challenge to parents lies in sorting out which pets are better left for when the children grow older. In making this decision, parents also need to be aware of actions that can be taken to reduce the risk of suitable pets harming their children.

According to the Centers for Disease Control and Prevention (CDC), pets that are generally not recommended for children under the age of five due to the risk of disease include reptiles (e.g. lizards, snakes, turtles), amphibians (e.g. frogs, toads and salamanders), baby chicks and ducklings. Animals taken directly from the wild such as raccoons or skunks are also unsuitable, as are exotic pets such as monkeys, prairie dogs or hedgehogs.

Perhaps surprising to some, puppies and kittens under the age of six months are also not recommended for small children. Not only are these animals more likely to nip at and scratch children, but also they are more likely to shed organisms – such as roundworm or hookworm eggs, and Salmonella, Campylobacter and Giardia – that are potentially harmful to children.

So what pets can children have? Adult dogs and cats are good choices. Even then, it is important to choose a breed that is good with children; some are not. The American Society for the Prevention of Cruelty to Animals (ASPCA) is a good source of information on this subject (and also a good source of pets).

In addition, any animal that has been bred to be a pet and is kept in a cage – rabbits, hamsters, guinea pigs, parakeets – is, for the most part, of lower risk to a child if s/he is taught how to handle the animal properly and an adult supervises the animal's care, including cleaning the cage. Fish are the best best, provided that children keep their hands out of the bowl.

Is it possible that exposure to pets may actually immunize your child against future diseases? Interestingly, a study suggested that children that live with these

types of pets may have a lower the risk of gastroenteritis compared with children that live with no pets at all; however, other studies have reported the opposite to be true.

If you choose to have a small pet at home, there are a number of things you can do as a parent to help minimize the risk of harm to your child (and to the pet) and maximize the fun. Perhaps most important is to supervise young children when in the presence of pets. The CDC also reports that children under the age of four are more likely to be bitten by animals than any other age group. While you may believe that your golden retriever wouldn't hurt a fly, any animal has the potential to bite or scratch and inflict serious damage given the right trigger. Such provocation may include unintentional acts by the child such as startling the pet when it is sleeping or poking the pet on a sensitive part of its body. Likewise, it is important to prevent dogs or cats from sleeping with babies unsupervised.

Parents can also do the following to keep risks to a minimum:

- Choose pets that have been certified healthy by a veterinarian.
- Provide pets with regular veterinary care.
- Keep pet feces out of the child's reach by cleaning litter boxes daily or "stooping and scooping."
- Teach your child how to play with and handle the pet gently.
- Teach your child to wash his/her hands with soap and running water after handling any animal.
- Discourage children from putting their hands or other objects (including food) in their mouths while playing with pets.

The above guidelines are provided with the assumption that a child is healthy to begin with. Additional precautions may be warranted under circumstances where a child is asthmatic or immune-compromised. If this is the case in your family, it is recommended that you consult with your pediatrician prior to bringing any animal into the home.

Dr. Lefebvre received her DVM from the Ontario Veterinary College. She is currently a PhD candidate in epidemiology at the University of Guelph, Ontario. Her research interests are in the human-animal bond and companion animal-associated zoonoses (diseases transmitted from animals to humans).

Rickets

By Ambika Mathur, PhD, and Deepak Kamat, MD, PhD

Rickets, a childhood condition in which your child's bones become weak, is not just a disease of the past but is still seen frequently in the United States. Rickets is caused by a failure of growing bones in children to take up calcium in adequate amounts. This can result in bones that become weak that can then easily bend and break. This failure of bones to mineralize can be caused by genetic conditions as well as nutritional deficiency.

Occurrence of Rickets

Rickets occurs in children who have insufficient intake of vitamin D and calcium, two of the most essential nutrients for bone growth and development. This insufficiency may be caused by a genetic mutation (a condition that is inherited from one or both parents (or that can be spontaneous)) or a nutritional deficiency. Many babies who are breastfed and are not exposed to sunlight develop rickets because breast milk does not have sufficient amount of vitamin D. Since sunlight is required for a baby to produce vitamin D, an absence of sunlight means the baby is not able to produce vitamin D. Rickets is more common in dark-skinned babies who do not receive sufficient exposure to sunlight. Babies who were premature or have kidney or intestinal disease can also develop rickets.

Presentation and Diagnosis of Rickets

Children with rickets have weak bones that can bend and break easily. In these babies the skull is generally soft and the babies tend to be irritable. In infants and toddlers, this abnormal bone development may result in the child not being able to develop and grow properly. They are also unable to walk properly. Older children with rickets often complain of pain in the bones and have bow-legs, which worsen as the child grows, and they can also have wide wrists and knees. In such cases the healthcare provider obtains the history of both the child and the family, as well as a history of the child's diet. The physician will also perform a complete physical examination and look for signs of rickets. If any of these clinical signs are seen in your child, if a member of your family has rickets, or if the child's diet lacks adequate calcium or vitamin D, the doctor may suspect that your child has rickets. Usually X-rays and lab work confirm the diagnosis.

Treatment and Prevention of Rickets

If your child has the inherited or genetic form of rickets, or if the rickets is due to another underlying condition such as kidney or intestinal disease, your primary care

physician will refer the child to the care of a specialist, usually an endocrinologist. Your child will probably need to take a prescription vitamin D supplement that helps his body process vitamin properly.

Nutritional rickets is easier to treat since parents usually just need to provide their child with adequate amounts of vitamin D and calcium that are found in a healthy diet. This form of rickets is preventable by ensuring that your child is exposed to adequate and safe amounts of sunlight and is provided with dietary vitamin D and calcium that are required for proper formation, development and growth of your child's bones. This is especially important in babies who are breastfed. In such cases, supplementation of vitamin D in your baby's diet is important. In fact, due to the increasing frequency of nutritional rickets in the U.S., it is now recommended that all babies who are solely breastfed should receive daily Vitamin D supplementation beginning in the first two months of their lives. Older children may also require supplementation of their diets with calcium and vitamin D. In order to prevent rickets in older children, it is essential that they have a diet rich in vitamin D and calcium, nutrients that can be found in fortified dairy products.

Conclusion

The primary goal of early diagnosis and treatment of rickets is to prevent further abnormalities in the growth and development of the child, and especially to prevent severe deformities that would require corrective surgery. Nutritional Rickets, in particular, is easily preventable and treatable by safe exposure to sunlight and adequate dietary calcium and vitamin D consumption.

Dr. Mathur is an adjunct professor at the Carman and Ann Adams Department of Pediatrics at Wayne State University and the Children's Hospital of Michigan. She is also associate director of the Institute of Medical Education. A tumor immunologist by training, Dr. Mathur has also written and published a series of educational books for children ages 4-10, and is deeply committed to promoting literacy among children.

Dr. Kamat is a professor at the Carman and Ann Adams department of pediatrics at the children's Hospital of Michigan and Wayne State University. He is also the vice chair of education, director of the Institute of Medical Education and program director for the International Health Pathway.

Your Questions Answered

Roy Benaroch, MD, answers your questions this month. He practices in Atlanta, GA. and is a frequent contributor to the newsletter and the Pediatrics for Parents podcast. Sharon Fried Buchalter, PhD, is a distinguished clinical psychologist, family/marriage therapist, relationship expert and author.

Send your questions to QandA@pedsforparents.com or Pediatrics for Parents, PO Box 219, Gloucester, MA 01931. Please keep them general in nature as we can't give specific advice nor suggest treatment for your child. All such questions should be asked of your child's doctor.

MRSA

Q My two-year-old son has had boils on his thighs since October 2007, which have been diagnosed as MRSA. Since then, and after additional boil outbreaks, the boils increased in redness, hardness and temperature. After treatment in an ER, the boils were pus-filled and purple. Why would this be happening? We have a clean house, the daycare he attends is clean, his clothes are washed after each use, his bedding changed frequently. My son is in so much pain with these occurrences. I don't know what to do, and the medical staff hasn't been very helpful.

A MRSA (methicillin resistant staph aureus) has become a very common cause of infections in children and adults. Usually, it causes infections in the skin such as boils or impetigo; more rarely, it can cause serious infections of the lungs or bones. Most children who get MRSA infections come from ordinary, clean homes with good hygiene. It is not particularly an infection that has anything to do with having a dirty home or unclean school. Though MRSA is resistant to many antibiotics, there are still good antibiotics available to treat these infections.

If your child has a boil or a pus-filled pocket, it is important that a doctor open up the area and drain the pus. Draining MRSA infections, when possible, is essential to getting a cure – and far more important than which antibiotic is chosen. Because resistance to antibiotics occurs with these infections, your doctor should always “culture” the material from an infected wound by collecting some of the pus on a swab for the laboratory. At the lab, the bacteria will be identified and tested against a panel of different antibiotics to see which ones kill it the best. Your doctor can then know the best way to treat your child.

Cases of recurrent MRSA infections occur, and can be very frustrating. There is no 100% method that always eradicates the bacteria, so exactly what steps to follow needs to be individualized by a physician who is experienced in treating MRSA. Some steps that can be

helpful include: soaking the child in a diluted bleach solution in the tub, washing with medical soaps, showering after sports, or using combinations of oral and topical antibiotics. Sometimes, special antibiotics that are otherwise rarely used in children are needed. For a second opinion, you may wish to request a referral to an infectious disease specialist.

Roy Benaroch, MD

Sleep Problems

Q We have 5-year-old twins and we are finding it a huge struggle to get them to sleep at night. Please, please, please help us! Do you have any tips on how we can correct this problem?

A You are not alone! Bedtime can often be a struggle for many families – but it doesn't have to be. The most important thing you, as parents, need to remember, is that while your children are not yet adults, they are people. They have feelings and are at an important stage of growth where they are most likely trying to exert their independence. When at school, teachers and authority figures are in control; therefore, children often try to exert their independence when they get home. It is the beginning of becoming their own people, establishing their individuality.

The question I am asked often is how, then, as a parent, can I give my children what they want and need, but still have them get to bed in a timely manner? The following are some tips that might help:

- Before going to bed, give your children some time with you to tell you about their day and to vent. Often children just want to spend more time with their parents and talk.
- Sit down with your children and create a bedtime ritual. Have your children help create this ritual with you. For example, read a story, sing a song, cuddle, etc. Routines are very important, especially at younger ages, such as 1-3 years old. A bedtime routine gives children a sense of security and stability.

- Start your children's bedtime ritual about 30 minutes to an hour prior to your their actual bedtime. Use this as a quiet time for your children to wind down; try to avoid activities that will stimulate or excite them during this time.
- Respect your children's sense of time by telling them that their bedtime will be in 15 or 30 minutes. This allows them to finish whatever they are doing prior to going to bed.
- Offer your children some choices. This will give them a sense of control over what happens to them. For example, you could give them a choice of two different sets of pajamas from which to choose. Or, you might ask your children if they'd rather take a bath or a shower before bed.
- Respect your needs as an adult. Take care of yourself during the day so you are not feeling frazzled and exhausted when it's time to put your children to bed. Children can sense their parents' frustrations and anxiety.
- Set your children's bedtime at a time that allows you and your spouse some "alone time" after your children go to bed. This is healthy for your relationship as a couple.
- If your children get out of bed after going to sleep, instead of talking and getting into a power struggle, lovingly guide them back to bed. You may have to guide them back to their room several times, particularly at the beginning, because children will test their parents. Eventually, however, bedtime will become more pleasant for both you and your children.
- Make bedtime a time for closeness, shared communication and nurturing. By involving your children in the decision-making process and spending special time with them, they will feel valued and respected. By setting limits, you will gain the respect of your children and help build their self-esteem.

Sharon Fried Buchalter, PhD

Picky Eater

Q What's the best way to prevent my children from becoming picky eaters?

A There is good evidence that taste preferences can begin to form before babies are born! So during your pregnancy, eat a good variety of balanced foods. After your baby is born, it is much better to nurse than formula feed. Nursing exposes your baby to a variety of flavors from the foods that moms eat, rather than the exact same flavor formula day after day.

Start solids between four and six months, and try to set an example by eating as a family as often as pos-

sible. Your baby can begin to eat some of your "adult food" by nine months, and this is a great time to really expand the number of foods Junior can try. Offer foods non-judgementally, right off of your plate, and let your child touch and squeeze the food to better appreciate the texture. Don't be afraid of a mess, and don't start wiping your baby's mouth over and over! Let her enjoy herself.

As your baby gets older, offer her ONLY the foods that the rest of the family is eating, and eat together with her at every meal. Don't focus on how much she eats. Use mealtimes to talk about other things that are going on that day. Set a good example by eating a variety yourself, using utensils, and drinking tap water. It may take 10 or 20 trials of a new food for a child to accept the flavor, so don't give up and say things like "Oh, she doesn't eat that!" Just offer a little morsel of this and that again and again, and don't worry about whether it's being eaten.

There's no guarantee that any child will want to have a varied diet as an adult, but we know that a restrictive or controlling feeding style, with limited exposures to variety, is much more likely to lead to a child with a persistently limited diet. Remember: a parent's job is to offer nutritious foods in an appropriate way, and the child's job is to decide how much, if any, of it to eat.

Roy Benaroch, MD

Car Seat Placement

Q I was wondering what is the best placement in a car to put the car seat if I only have one child. Is the middle space really the safest or is a side better?

A Yes, the safest place for a car seat is in the middle of the back seat because it is the farthest from a door, where impact could occur. If you have a car or van that doesn't have a middle, or has a "hump" in the middle that prevents a car seat from being installed correctly, the second best place is behind the driver. T-bone style collisions are more common on the passenger side, probably because the driver has poorer vision out the passenger window than out the driver's window. It's not a huge difference, but given a choice it's safer to sit behind the driver than behind the front passenger.

Roy Benaroch, MD

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It's on iTunes, our website, and
www.pedsforparents.libsyn.com**

Emergencies – Continued from page 11

exaggerate or downplay what needs to be done. If a child needs a painful procedure, it's best to say that it may hurt briefly rather than say it won't hurt at all.

5. Never hesitate to ask questions.
6. Show support for the medical staff – Difficult when waiting in the ED, but your child needs to feel that you have confidence in his doctors and nurses and the treatment he is receiving.
7. Keep your child distracted – Depending on the urgency of your child's illness or injury, the time of day and other factors, you may be in for a long wait with your child in an ED. Use books, writing materials, games etc. Many children's EDs have TVs in the rooms and Child Life Specialists who can supply books and games if necessary.

Martin Belson, MD, is a pediatric emergency medicine physician at Children's Healthcare of Atlanta at Scottish Rite, a medical toxicologist, creator/editor of www.kidemergencies.com and host of the Pediatric Health Hour every Wednesday at 9AM on www.radiosandysprings.com. www.kidemergencies.com, a user-friendly, free resource on children's health emergencies and poisonings is one of five websites that has received the iParenting Media Award for the Greatest Products of 2007.

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