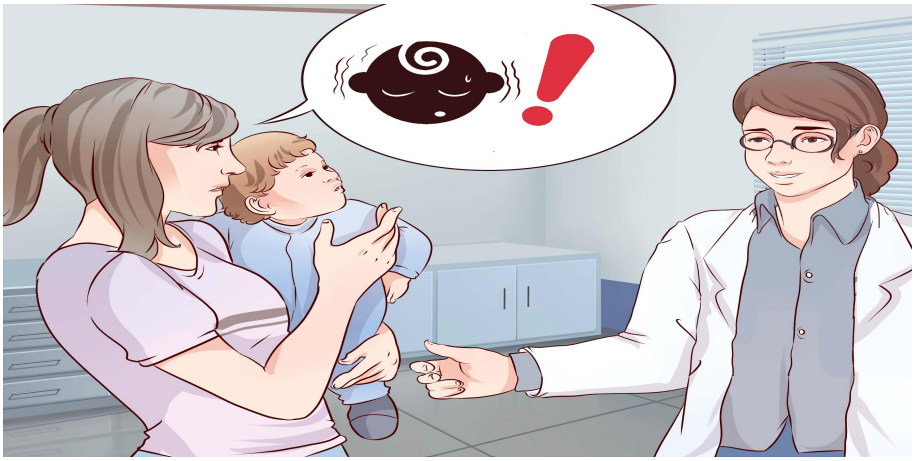
Pavilion Pediatrics Fall Newsletter

September 2018



Is Something Going Around?

We here at Pavilion Pediatrics sometimes laugh when we get the question: “Is something going around?” Not because it’s a silly question - in fact it is spot on - but because there is ALWAYS something going around. It’s the nature of the bacterial and viral world. What can they say: they like to visit. There is some predictability, however, to when certain viruses tend to circulate. This mostly has to do with host factors, meaning how and where we congregate, eg: swimming pools, camps, schools, airplanes, etc...For example, late summer is prime time for some of the viruses that cause Hand, Foot, and Mouth Disease to circulate. Let’s clarify a few things about **Hand, Foot, and Mouth**. First, we agree: it sounds like nothing you’d want anyone in your family to get. It sounds almost bucolic, and not in a good way :). And it sounds contagious, what with all the body parts in the very name. It however, is usually a pretty tame thing. In fact, Hand, Foot, and Mouth does not specify one viral infection in particular. It is instead a description of symptoms that many different viruses can cause: ulcers in the back of the mouth, and bumps on the skin, commonly but not exclusively on the hands, and feet. That’s it. Sometimes,

but not always, children and adults will also have other viral symptoms such as a runny nose, cough, and fever. Since Hand, Foot, and Mouth is caused by viruses, antibiotics are of no use in treating the virus. The key to helping your child through Hand, Foot, and Mouth - just like the key to weathering most any virus - is keeping your child comfortable enough so that he or she drinks (and hopefully eats) enough to stay well hydrated. Because children with Hand, Foot, and Mouth often have ulcers in the back of the mouth, this is usually the trickiest part. We recommend using a pain reliever such as ibuprofen or tylenol and encouraging fluids, and soft, soothing foods such as yogurt, pudding, and popsicles. All in all, the virus usually lasts 3-5 days, with the rash sometimes lingering a few weeks as it crusts over and disappears. In terms of contagiousness, since the symptoms are caused by a variety of different viruses, it's hard to know exactly, but as in most cases of illness, we use fever within the last 24 hour period as our best proxy for determining contagiousness. The rash itself is not contagious.

Another illness that sadly is ALWAYS going around is the dreaded stomach bug: contagious vomiting and diarrhea. If you're like me, a hallmark of being a parent of young kids is dreading the stomach bug like the plague. It is so darn contagious and well, ...unpleasant. The only saving grace of the stomach bug is that, in most cases, it is short-lived. Often the vomiting phase of the illness lasts only 12-24 hours, with diarrhea following, often lasting a week or two, with gradual improvement. The key to managing a stomach bug, or **acute viral gastroenteritis**, is again, making sure your child stays hydrated. This can be tricky when he or she is having a hard time keeping anything down. What we recommend is offering small frequent sips of a liquid with some sugar or salt content - for infants, breastmilk or formula, or, if this isn't tolerated, pedialyte; and for children and young adults, a drink like Gatorade with electrolytes. You may offer only an ounce or two at a time, and if they keep this down, offer another few ounces in 20-30 min, and repeat until they are able to handle larger volumes. All the while, keep an eye on your child's urination. We'd like them to be urinating at least once in a 6-8 hour period. Once your child is

tolerating liquids, you many try to offer some bland solids, like crackers. It is advisable to avoid greasy foods and dairy products (with the exception of breastmilk and formula) as these may irritate the gastrointestinal tract immediately following the stomach bug. If your child's urine output falls below the recommended interval of 6-8 hours, or if he or she appears too weak to feed (infant) or get up and walk around (child and young adult), please contact your pediatrician as it may be necessary for your child to be seen in the Emergency Department to receive intravenous fluids in order to maintain proper hydration. In most cases, however, stomach bugs can be handled exclusively at home. Sadly, there is not much we can do in the office for them. But we are always happy to chat over the phone to guide you through managing at home.

Fall Reminders

- The 2018-2019 flu vaccine will be available in early October. We recommend ALL children, over six months of age, receive the vaccine each year. Infants or children under eight receiving the vaccine for the first time will need two injections in the first year, separated by one month. All other children will need only one injection. We recommend vaccinating early in the flu season (October or November) so that your child is protected once the flu starts to circulate. Please call the office in late September to schedule your child's flu vaccine.
- As the seasons change, remember to prepare for seasonal allergies if your child is susceptible. Most commonly, we treat symptoms with oral antihistamines, but there are additional strategies as well. Be sure to discuss with your pediatrician as needed.
- If your child is prone to wheezing, be sure to have an adequate supply of rescue medication, such as albuterol, and controller medicines such as inhaled corticosteroids if they are part of your child's fall/winter treatment plan.

In the News

Car Seats: The American Academy of Pediatrics recently updated it policies regarding car seats and safety. Whereas the previous guidance had been that infants and children should remain in a rear-facing car seat until two years of age, the new guidelines advise following the manufacturer's height and weight limits stipulated for the particular car seat. Once a child has outgrown these, he or she may switch to a front-facing seat with a five-point harness, again until he or she outgrows the weight and height limits of the particular seat. After this, they may progress to a booster seat to allow proper positioning of the shoulder strap. Typically, children can sit in the backseat without a booster once they have reached a height of 4' 9", and it is advisable for all children thirteen and under to remain in the backseat. Should you have any questions or comments regarding the information found here, we encourage you to bring them to your child's pediatrician.

Pediatric Concussion: The CDC just released guidelines on the management of pediatric concussion. While the guidelines for concussion remain consistent with previously accepted evidence-based research, the publication creates consensus on the approach to management. Some of the highlights include:

- Confirmation that routine imaging (CAT scan, MRI, or x-ray) of the head should NOT be used to diagnose concussion. Emergency Department physicians will ascertain whether the symptoms present warrant imaging using a validated scoring tool. Routine blood work is similarly not useful in diagnosing concussion.
- Recommendation that providers use symptom checklists to aid in diagnosing pediatric concussion and communicate to families that each child's trajectory in healing from a concussion may be unique, influenced by personal factors and prior history of concussion or brain injury.
- Affirmation that children diagnosed with concussion should be counseled to rest both cognitively and physically for the first few days following the head injury, with gradual resumption of usual activities so long as there is no recurrence of symptoms.
- Recommendation that children with prolonged or persistent symptoms despite an active treatment approach be referred to a specialist trained in the treatment of concussion.

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