Knoxville Pediatric Associates, P.C.

Pediatric Care

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Michael Reiss, M.D., FAAP
Sarah E. Gilley, M.D., FAAP
Heather Cash, M.D., FAAP
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Laura Young, P.A.

FOOTHILLS PEDIATRIC CENTER LOCATION

245 Joule Street
Blount Memorial Health Center, Springbrook
Alcoa, Tennessee 37701
Phone (865) 982-7396
www.knoxpediatrics.com

INTRODUCTION

Knoxville Pediatric Associates welcomes you to our group and we are happy that you have chosen us as your pediatricians. Our goal is to provide the best possible care for your child while building close doctor-patient relationships based on trust and compassion. Please feel free to let anyone in our office know if you experience problems or have suggestions for improvement.

This handbook is designed to give you an overview of how our practice works and to provide you with some basic medical information on common pediatric problems. We hope this will be helpful both to new patients in our practice as well as to any of our patients with problems which might necessitate a phone call to the office or doctor on call.

Our practice has been formed by the merging of two of the oldest, most well-established pediatric practices in Knoxville, namely Knoxville Pediatric Group and Pediatric Associates of Knoxville. Subsequent to this merger, Foothills Pediatric Center in Alcoa in January 1998 merged with Knoxville Pediatric Associates, P.C. Within the larger merged group, there are now 5 offices which make up three distinct practice settings. The practice setting are the (1) Clinch and Park West offices, (2) Weisgarber and Farragut offices, and (3) the Foothills office. At each of these settings there are the same physicians; that is, if you go to the Foothills office you will always see one of the 6 doctors that are located at that setting and the same for each group of locations. Therefore, although we are now over 20 pediatricians in 5 offices, you will choose to be seen at one of the separate practice settings. As of this time, once you choose a practice setting, you will remain with that setting. We do not currently have the capability to share charts among the different offices and to enhance your quality and continuity of care we ask that you remain in one of the distinct settings mentioned above.

All of the pediatricians in the practice are board-certified and share common goals and objectives. Each of the discrete practice settings has its own personality and somewhat unique style of seeing patients. The individual location description for the Foothills office begins on the following pages.

FOOTHILLS LOCATION

232 ASSOCIATED BLVD.
SPRINGBROOK CORPORATE CENTER
ALCOA, TENNESSEE 37701

(865) 982-7396 Fax 983-0294
By Appointment only
Monday-Friday-8:00 AM-5:00 PM
Saturday 8am - 11:00 AM

Tommy Collins, M.D.
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Jane Holt, D.O.
Katherine Dabbs, M.D

Our Foothills location is in Alcoa just south of the airport in the Springbrook Corporate Office Center (please see map on back cover). We are in the large white building with a blue roof, the Blount Memorial Health Center at Springbrook. Patients are seen at the Foothills location by appointment only, which can be made by calling 982-7396 during the above office hours. When you call for an appointment, you will be asked which doctor you prefer to see. While you are not assigned to a specific physician, many patients prefer to see one pediatrician most of the time and others enjoy seeing different pediatricians at different times.

Typically, you will make your well exam appointments at the time of the previous well visit. Sick appointments, of course, cannot be predicted. It is our practice to see any patient needing to be seen on the day that they call to be seen if the call is in regular office hours. This means that your appointment may be for a later time than regular hours. It is only during rare exceptionally busy times that we are not able to see your sick child on the day that you call. To insure that you will be seen, please call as early during the day as possible after 7:30 am.

We are very interested in seeing you as promptly as possible at the scheduled time of your visit. There are unexpected, seriously ill patients or persons with unanticipated problems that at times take longer than expected. If you think that your situation might be one of these extra-long visits please notify the receptionist when you call. Because persons arriving more than 10 minutes after their scheduled time force a delay for all subsequent patients, we reserve the right to request that you reschedule if you are over 10 minutes late.

MEET THE PROVIDERS

Knoxville Pediatric Associates, P.C. prides itself in having the best pediatricians in the Knoxville area. Each pediatrician is required to maintain Board Certification by the American Board of Pediatrics. This means that all have completed and approved training program and subsequently passed a Board exam to insure that their skills are appropriate. Newly boarded pedia-tricians are also required to be recertified every 7 years. This is a baseline from which we continually try to build a practice that cares for your medical needs and as importantly care for you as a parent and your child as a patient. You can assist in our building this trust relation ship by keeping us informed of ways that we can improve our service.

Tommy Collins, M.D., FAAP

Dr. Tommy Collins joined Foothills Pediatrics in July 1992 returning to his wife, Kim's, East Tennessee roots. Kim currently practices gynecology in Maryville. Their two children's active involvement in the community include talents in music which Dr. Collins also shares. They are active in their church and all enjoy a winter ski vacation.

Beth Gilley, M.D., FAAP

Dr. Beth Gilley also joined Foothills Pediatrics in 1992 after beginning her practice of Pediatrics-Internal Medicine at Blount Memorial Emergency Room. Her husband, Jerry, works at Blount Memorial as an anesthesiologist. Both of their children are graduates of Maryville High School. They, along with their two children, enjoy outdoor activities. Dr. Gilley is an avid gardener and enjoys native plants and other eclectic perennials.

Mike Reiss, M.D., FAAP

Dr. Mike Reiss joined Foothills Pediatrics in July 2000 after being lured from his upbringing in the Northeast. His wife, Kathy, is an English teacher in the Maryville School System. Their two children are active in sports and school activities, and share an enthusiasm for adventure with their parents. Dr. Reiss is an avid runner, cyclist, hiker and kayaker.

Heather Cash, M.D., FAAP

Dr. Heather Cash returned to her home in Maryville to join Foothills Pediatrics in July 2004. She and her husband, Art, have two young children who provide Dr. Cash with plenty of on the job training for the practice of pediatrics. The Cash family is very involved in their church's activities and having two "full time" jobs is more than enough to keep Dr. Cash busy.

Jane Holt, D.O., FAAP

Dr. Jane Holt joined our practice in the summer of 2013. Dr. Holt is married to a Knoxville native. They have two children. She enjoys cooking, baking, bluegrass music and spending time with her family on the farm. She looks forward to having a few chickens of her own someday and maybe even a cow.

Katherine Dabbs, M.D., FAAP

Dr. Katherine Dabbs joined KPA Foothills in 2016. She is an East Tennessee native. Dr. Dabbs enjoys the outdoors. Some of her favorite activities are hiking, and of course, UT Football!

Laura Young, P.A.

Laura Young received her Masters Degree as a Physicians Assistant at South College in 2010. Before joining our practice, she worked for seven years in the Emergency Department. As an alumnus, she is an avid fan of Clemson football. Other interests include cooking, gardening, and spending time with her friends and family, especially her niece and nephew.

PRESCRIPTION REFILLS

Most prescription refills, if requested prior to 4 p.m., can be handled on the day requested. Please make sure you know the name of the medication, the dose, the form (liquid or tablet) and the name and number of your pharmacy. A nurse may call you to discuss the refill if the patient has not been seen for regular checkups or if the prescription needs to be adjusted.

Prescription refills for patients with Attention Deficit Hyperactivity Disorder take at least 24 hours, since by law they cannot be phoned to a pharmacy; you must have a written prescription which you can pick up at our office. Please plan accordingly.

To determine the cause of your child's symptoms and the appropriate treatment, it is in your child's best interest to be examined by a physician. Therefore, we only call in prescriptions for maintenance medications for chronic problems. We do not call in antibiotics for suspected infections.

ACCOUNTS AND INSURANCE

It is our objective to provide our patients with the best care at a reasonable cost. Inflation is growing for everyone including medical offices. Today, we find ourselves confronted with ever-increasing costs for almost every supply and service we use in rendering professional care. Therefore, we request that all charges be paid at the time of service. For your convenience we accept Visa and Mastercard.

We participate with many HMO, PPO, and POS insurance plans and we will file those insurance claims for you. Please remember that your insurance policy is a contract between you and your insurance company, and we are not a party to the contract. Therefore, financial responsibility for your child(ren)'s treatment is ultimately yours. You are responsible for all copays and deductibles at the time of service. You will also be asked to complete a patient information form on a yearly basis which includes insurance information.

If you have a type of insurance with which we do not participate, it will be your responsibility to pay at the time of service. The receipt (superbill) you receive is coded for insurance purposes and may be submitted along with your claim form as well as used for tax purposes.

In a divorce situation, the parent bringing the child for the appointment is responsible for payment at the time of service. Any payment arrangement set forth in the divorce decree is between the parents and does not involve our office.

Coverage under your insurance plan may not coincide with the American Academy of Pediatrics guidelines which we support in our practice. This is particularly true for well-child care.

For specific questions or problems you may contact someone in our business office between 8:00 A.M. and 5:00 P.M. at (865) 525-0040.

BOOKS WE RECOMMEND ON CHILD CARE

GENERAL PEDIATRICS

- Your Baby's First Year by Steven Shelov, MD
- Caring for Your Baby and Young Child : Birth to Age Five by Steven Shelov, MD
- Caring for Your School Age Child Ages 5 to 12 by Steven Shelov, MD
- Caring for your Teenager by Steven Shelov, MD
- Your Child's Health: The Parents' Guide to Symptoms, Emergencies, Common Illnesses, Behavior and School Problems by Barton Schmitt
- American Academy of Pediatrics Guide to Your Child's Symptoms: The Official Home Reference, Birth Through Adolescence by Donald Schiff, MD (Ed)

BREASTFEEDING

- The American Academy of Pediatrics New Mother's Guide to Breastfeeding by Joan Younger Meek
- The Nursing Mother's Companion by Kathleen Huggins
- The Breastfeeding Book : Everything You Need To Know About Nursing Your Child From Birth Through Weaning by Martha and William Sears
- So That's What They're For: Breastfeeding Basics by Janet Tamaro

VACCINE INFORMATION

- What Every Parent Should Know about Vaccines by Paul Offit and Louis Bell, MD
- Six Common Misconceptions and How to Respond to Them

NUTRITION

- American Academy of Pediatrics Guide to Your Child's Nutrition: Making Peace at the Table and Building
- Healthy Eating Habits for Life by William Dietz (Ed.)
- Coping with a Picky Eater: A guide for the Perplexed Parent by William G. Wilkoff
- Secrets of Feeding a Healthy Family by Ellen Satter

SLEEP

- Guide To Your Child's Sleep: Birth Through Adolescence by George Cohen, MD
- The Happiest Baby on the Block: The New Way to Calm Crying and Help Your Newborn Baby Sleep Longer by Harvey Karp
- Solve Your Child's Sleep Problems by Richard Ferber

PARENTING AND DISCIPLINE

- The Happiest Toddler On The Block: The New Way to Stop The Daily Battles of Wills and Raise A Secure and Well-Behaved One-to-Four Year Old by Harvey Karp and Paula Spencer
- Discipline Without Shouting or Spanking by Wykoff and Unell
- PET: Parent Effectiveness Training by Thomas Gordon
- Making Children Mind Without Losing Yours by Kevin Leman, MD

TELEPHONE ADVICE

If your call concerns a life threatening emergency, such as a seizure or loss of consciousness, state this immediately to the first person who answers the phone. Our medical staff is trained and available to answer many of your questions over the phone such as whether or not an office visit is necessary, the correct dosage of medication or advice about minor illnesses. If a phone call is still needed from a doctor after speaking with one of our nurses, your call will be returned when the doctor is not with patients who are in the office. This may be after morning or afternoon office hours.

Certain symptoms nearly always require a doctor's examination: earache, sore throat, skin rash, severe abdominal pain, painful urination or prolonged fever. Examination of your child is essential to make a proper diagnosis; therefore, we will not phone in an antibiotic without an evaluation in one of our offices by a doctor.

Discussions regarding school, emotional or behavior problems are best conducted by appointment in the office. Telephone discussions are too often unsatisfactory. The doctor on call is available after hours to discuss only urgent or emergency problems. We understand that to parents any concern about their child can be considered urgent, but medication refills, feeding schedules, constipation and non-life threatening symptoms are better handled during regular office hours when your child's office chart is available. Our goal over the phone is to help you make decisions about your child, but we cannot diagnose and treat over the phone.

After regular business hours, your call will be answered by the After Hours Program at East Tennessee Children's Hospital. By asking you a series of questions, a pediatric registered nurse will assess the condition of your child and give you immediated detailed medical advice. The hurse may give you home instructions to follow, suggest you visit our office the next day or tell you to bring your child to the Emergency Department at Children's Hospital or another hospital near you. The next day we will receive a complete report concerning your call.

INSTRUCTIONS FOR NEWBORN CARE

During the next few days, most of your time will be spent in resting and regaining your strength. You can put this time to good use by getting to know some of the simple things which will help to make life with your baby easy and fuss-free.

Parenthood is one of the most exciting experiences you will ever have, but it is also a bit frightening, especially if you are a parent for the first time. We will assist you in gaining confidence in your parenting. Parenthood is one

of the most exciting experiences you will ever have, but it is also a bit frightening, especially if you are a parent for the first time. We will assist you in gaining confidence in your parenting skills here in the hospital and also during the first weeks and months at home. We encourage you to read this booklet and discuss any questions you have at our daily hospital visits. We also encourage you to nurture your family relationships as this is important to the well being of your baby.

You will quickly discover that your baby has a unique personality just as every adult does. Some babies are quiet, docile and even tempered. Others are irritable, always hungry and poor sleepers. Most are between these extremes.

We view our main job as that of educating you in the science and art of parenting. In our well baby visits, the doctors and nurses will cover aspects of feeding, discipline, safety and disease prevention as they apply at different ages.

INFANT SLEEPING POSITION AND SIDS

Parents and caregivers should place their healthy infants on their backs when putting them down to sleep. This is because recent studies have shown an increase in Sudden Infant Death Syndrome (SIDS) in infants who sleep on their stomachs. There is no evidence that sleeping on the back is harmful to healthy infants.

- Do not place your infant to sleep on waterbeds, sofas, soft mattresses or other soft surfaces. Pillows, quilts, comforters or sheepskins should not be placed under your baby.
- Devices designed to maintain sleep position or to reduce the risk of rebreathing are not recommended since many have not been tested sufficiently for safety. None have shown to reduce the risk of SIDS.
- Do not smoke during pregnancy; continue to provide a smoke-free environment for your baby.
- Make sure your baby does not get overheated. Keep the temperature in your baby's room so it feels comfortable for an adult and dress your baby in as much or little clothing as you would wear.
- A certain amount of "tummy time" while the baby is awake and observed is recommended for developmental reasons and to avoid flat spots on the head.

TRANSPORTATION

An infant car seat should be used at all times, even for the baby's ride home from the hospital. Infant car seats are designed to face rearward. The infant, semi-reclined, is secured in the seat with a harness,

and the seat is secured to the vehicle with a lap belt. An infant car seat is designed to be used for children under 20 pounds. There are also convertible seats which may be converted from an infant seat to a toddler seat to accommodate children from birth to 40 pounds. The use of infant car seats is required by the law in Tennessee. Do not confuse approved, sturdy child restraint devices with bouncy seats or shopping carriers. Be mindful of your own vehicle's recommendations regarding the use of car seat positioning and airbags.

COMFORT

CLOTHING:

Usual indoor dress should include only a diaper and a gown or one piece stretch suit. Socks, sleepers, and undershirts can be added in the winter. The best materials are cotton and cotton-polyester blends. During the first six months, washing with Ivory or Dreft is preferable to harsher detergents. Avoid using paper fabric softeners. In an automatic washing machine, normal washing procedures may be used with a mild soap or detergent. Disposable diapers may be used, and are more convenient, but also more expensive. Some babies may be allergic to certain brands of disposable diapers.

ENVIRONMENT:

Try to keep an even, comfortable temperature in the baby's room. On hot days provide ventilation. On cold days check on your baby occasionally to see that he/she is covered enough to be warm and comfortable. An environment free of tobacco smoke is healthier for your infant. You should avoid exposing a young infant to people with infectious diseases.

OUTDOORS:

Young babies can be chilled when outdoors for a short time. Therefore, in the winter, especially when very cold and windy, heavy blankets and caps are advisable. During the warm months, care should be taken to avoid sunburn and to maintain adequate fluid intake. Short sun exposure in midmorning and later afternoon is advised, starting with only ten to fifteen minutes per day. Long term exposure to the sun should be avoided. Sunscreen should be used after 2 months of age.

SLEEPING:

At first the baby will eat, then soon afterwards go to sleep. Recently the Academy of Pediatrics has recommended positioning an infant on his/her side or back to decrease the risk of SIDS. The mattress should be flat. A waterproof cover may be used to protect the mattress. No pillow should be used. He/she should be covered with one thin blanket in the summer. In the winter, a quilt or thicker blanket should be used. Do not overdress the baby

because this interferes with his/her arms and legs. From the first, your baby should go to sleep on his/her own, that is without rocking, patting, or singing. These measures should never be used to get an infant to sleep because they are extremely difficult to stop later. A night light is optional, but remember this too would be difficult to discontinue later. If you use a crib or bassinet in your room, your baby should be sleeping in his/her own room between 3-6 months. The average age for sleeping through the night is about 9 weeks and for the most part is unrelated to feedings.

Although the recommended sleep position is on the side or back, it is important that your baby spend some of his or her waking hours in the prone position (on the tummy). This is beneficial for your baby in that it helps neck and shoulder muscles to develop and is in no way harmful for your baby. Remember: "back to sleep, prone to play".

OFFICE VISITS:

Your baby should have the first office visit 1-3 days after hospital discharge, then the first office check-up at 4 weeks of age. You will be seen in the hospital by the doctor assigned for hospital rounds. You should schedule your first office visit as directed by that doctor. It may be the next day following discharge or up to 3 days later depending on the length of your hospital stay and presence of jaundice or feeding problems. After discussion with the doctor in the hospital, please call the office of your choice for an appointment. You do not necessarily have to see the doctor that has seen you in the hospital.

Along with the check-up examination we will want to discuss your baby's growth, development and the many interesting things that you can expect your baby to do within the next few months.

Be sure to bring along extra diapers and a bottle of formula (if bottle feeding) when you come to the office.

IMMUNIZATIONS:

Immunizations (baby shots) are very important, and it is recommended that your baby receive the Hepatitis B vaccine while still in the hospital. Your baby will receive the first "set" of immunizations at 2 months of age. A complete immunization schedule will be given to you at the first office check-up.

The physicians of KPA support that all children be immunized according to the schedule of vaccines as outlined by the American Academy of Pediatrics. Recent increases in preventable disease in the unimmunized support that universal immunization is necessary. Our goal is to prevent serious diseases from striking our patients by fully immunizing them. We will begin discussing our policy in support of vaccines at the prenatal visit or prior to transfer for new patients. We trust that our patients will be understanding of our support of the American Academy of Pediatrics and its vaccine schedule.

EMERGENCIES:

Should an emergency arise, call immediately. One of us is always available. If you receive no answer at the office, call the designated after hours office number and the doctor or nurse on call will be paged and call you back as soon as possible. It will be greatly appreciated if formula changes and routine questions would be limited to regular office hours.

FRIENDS AND RELATIVES:

These people are interested in your baby and want to hold and hug. Unfortunately, you may not know who has a cold, sore throat, cough, decayed teeth, or dirty hands. Do your best to protect your baby from infections. Good hand washing prior to anyone handling your baby is always important. We also reccomend that your baby stay away from crowded public areas (e.g. church, mall, stores) until 6-8 weeks fo age.

FEEDING:

Feeding is one of your baby's first pleasant experiences. The baby's first love for its parent arises primarily from the feeding situation. At feeding time your baby receives nourishment from food and also nourishment from mothers's love. The food, correctly taken, helps the baby to grow healthy and strong. The parent's love, generously given, helps the baby feel secure. Help your baby get both kinds of nourishment.

Both of you should be comfortable. Choose a chair that is comfortable for you. This will help you be calm and relaxed as you feed your baby. Your baby should be warm and dry so that baby is comfortable too.

Hold your baby in your lap, with the head slightly raised, and resting in the bend of your elbow. Whether breast feeding or bottle feeding, hold your baby comfortably close.

FOR BREAST FEEDING:

The most important keys to successful breast-feeding are confidence practice and relaxation. Breastfeeding is a learning experience for both you and your baby. If you are relaxed, your baby will pick up on your cues and will nurse better. Nursing should begin early in the first day of life and ideally within an hour from the time of birth. Rooming-in is helpful in that the baby can be fed "on demand" instead of waiting for a scheduled "feeding time". Cues that your baby is hungry include opening his mouth and sticking out his tongue while turning his head to either side, sucking on his hands, and gentle stretching of his arms and legs.

Many first-time mothers feel that they do not have an milk. In fact, you do! Colostrum is a clear or yellow fluid that is produced in the first few days. It is produced in small quantities but contains protective white blood cells that are important in fighting infection. It is an ideal food for the newborns because it is easy to digest and stimulates the baby's first bowel movement.

Newborns do not need any fluids other than colostrum (the exception is the baby with low blood sugar). Supplemental feedings of water or formula may cause the baby to lose interest in the breast and to nurse less frequently than needed. Supplemental water may also increase the baby's jaundice or yellowness. Bottle feeding and breastfeeding require different types of sucking. For the breastfeeding baby, bottle feeding may (1) lessen the baby's instinctive efforts to open her mouth wide, (2) condition her to wait to suck only when she feels a firm bottle nipple in her mouth, and (3) encourage her to push her tongue forward which is the opposite of what she needs to do for nursing. The baby who has bottle fed may also become frustrated while nursing, since milk does not flow as rapidly from the breast as it does from a bottle. For these reasons, we recommend that you delay introducing a bottle and pacifier until your baby is 3 weeks of age, when breastfeeding is second nature and your milk supply is established.

GETTING STARTED: For most women, sitting up in bed or a comfortable chair is easiest for breastfeeding. Make sure you are relaxed before you put your baby to the breast. Use pillows on your lap, under you arms and behind your back. Putting your feet on a footstool to raise your knees slightly above your hips will eliminate back strain.

Make sure your baby is comfortable and feels secure and supported. Nestle your baby in your arm at the level of your breast. You may use the cradle or cross-cradle hold. Two alternative positions are the football hold and lying down. These positions are especially helpful if you have had a Cesarean section. The baby should be turned toward you, chest to chest with his head and trunk in a straight line so that he doesn't have to strain and turn his head to attach to your breast. Tuck your baby's lower arm around you. If necessary, hold his upper arm gently with the thumb of your supporting hand. Be careful not to tilt his head as it will be difficult for him to swallow in that position. A very slight extension of his head with his chin touching your breast will help keep his nose clear.

Hold your breast with your fingers underneath and thumb on top, making sure all of your fingers are placed well away from your areola. It is sometimes helpful to roll your nipple between your fingers for few seconds to help it become more erect. Then manually express some colostrum to entice your baby to take your breast.

Gently tickle your baby's lower lip up and down with your nipple to encourage him to open his mouth wide. Be patient! The moment he opens wide, almost like a yawn, quickly pull him close to you. Do not lean forward, trying to put your breast into his mouth. Instead, pull him toward you so that he has a large mouthful of breast, including the areola. He is latched on well if his lips are flanged (upper lip is turned upwards and lower lip is turned downwards) and his nose and chin are touching your breast. Do not worry that your baby cannot breathe in this position. His nostrils are shaped to allow adequate breathing while nursing.

Breastfeeding should not be painful. If you feel any pain after your baby starts sucking rhythmically, stop and break the suction by inserting your finger into the corner of his mouth between the gums and slowly easing your nipple out of his mouth. Then try again. Don't be discouraged! Latching-on may take several attempts. Latch-on discomfort is common in the first few days but any pain should subside in a few seconds.

For the first 10 to 14 days, try to breast-feed every 2 to 3 hours during the day (times from the beginning of one feeding to the beginning of the next) and every 3 to 4 hours at night. Try to nurse for 15 to 20 minutes on each side. Burp the baby after each side and if he is sleepy, change his diaper or expose him to air to arouse him for the second side. Begin the next feeding on the side you ended on. After 2 weeks, let him nurse until the first breast is empty and then finish off on the second breast to ensure he receives your rich hindmilk. You should hear swallowing and notice that your breasts are softer after nursing. Your baby is finished on the first side when he/she comes off the breast after 10 minutes of constant swallowing or falls asleep.

Be sure to rotate positions to empty all ducts and to prevent sore spots. Air dry nipples 5 to 10 minutes after each feeding. You may use expressed breastmilk or modified lanolin (Lansinoh) on your nipples. If you use lanolin, do not apply it to the face of the nipple as this may plug the milk ducts and result in mastitis.

Keep a record of your baby's feedings, wet diapers, and bowel movements for the first 2 to 3 weeks or until your baby has had appropriate weight gain and your milk supply is well established. Most babies lose 5 to 10% of their birth weight within the first couple of days. It usually takes 1 to 2 weeks to regain to birth weight. By at least 2 weeks, most babies gain 4 to 7 ounces per week for the next few months.

Your baby should have at least 1 wet diaper on day 1, 2 to 3 wet diapers on day 2, 3 to 4 wet diapers on day 3. Your milk will come in around the 3rd to 5th day. When your milk comes in, you should see 6 too 8 wet diapers per day. The stools on the first few days will be tarry and

black (meconium) but should become liquid, yellow, seedy stools after your milk comes in. Your baby usually will have several bowel movements per day but some babies go 3 to 4 days in between stools when they are several weeks old.

How to know if your baby is getting enough milk:

1. Has 6 to 8 wet diapers each 24 hours after 4 days of age.
2. Has 1 to 2 bowel movements each day.
3. Takes some 2 hour naps and acts content after most nursing sessions.
4. Mother's breasts are softer because milk was removed during nursing.
5. You can hear baby swallowing during feedings.
6. Baby begins gaining weight in the second week of life at a rate of 4 to 7 ounces per week.

FOR BOTTLE FEEDING:

When breast-feeding is not desired, there are a variety of commercial formulas available. Unless otherwise specified, continue to feed your infant the formula which was begun in the hospital. There are now many advertisements and coupons for infant formulas. We ask that you disregard these unless they are for an approved formula. If you have questions about infant formulas and particularly if you feel you should change your baby's formula, we want to discuss your questions. We recommend formulas which are best suited for your baby's nutritional needs and should be continued until we tell you otherwise. The formulas we recommend are all iron fortified. Babies must have iron in small amounts. Without this small amount (11-12 mg./day) of iron, red blood cells will not develop and your baby will become anemic. This amount of iron will not cause abdominal pain, colic, gas, vomiting, diarrhea, or constipation.

The formulas are available in 32-ounce cans of ready to feed, 13-ounce cans of concentrate, or 16-ounce cans of powder. The ready to feed is poured into the bottle. The concentrate is mixed with 13 ounces (equal parts) of water. The powder is mixed in 2 ounces of water and 1 scoop of powder.

Bottles and nipples should be thoroughly cleaned in a dishwasher prior to preparation. TERMINAL STERILIZATION IS NOT NECESSARY UNLESS WELL WATER OR SPRING WATER IS USED. (DO NOT BOIL WATER, BOTTLES OR NIPPLES.)

It can be dangerous to heat a bottle in the microwave because the milk heats quickly and unevenly. If you choose this way to heat bottles, be very careful to heat for only seconds at a time, to shake the bottle thoroughly, and only after testing should the bottle be given to the baby.

Either disposable plastic bag nursers, plastic bottles or glass bottles should be used. Any nipple that is comfortable to the baby is acceptable. The nipple holes must be large enough to allow milk to come out rapidly in drops but not in a constant spray or stream.

Seated comfortably and holding your baby, hold the bottle so that the neck of the bottle and the nipple are always filled with formula. This helps your baby get formula instead of sucking and swallowing air. If the baby doesn't waste energy sucking air, enough formula will more likely be taken. Air in the stomach may give a false sense of being full and may also cause discomfort.

Your baby has a strong natural desire to suck. Sucking is part of the pleasure of feeding time. Babies will keep sucking on nipples even after they have collapsed. So take the nipple out of your baby's mouth occasionally to keep the nipple from collapsing. This makes it easier to suck, and lets the baby rest a bit. (Be sure to follow our instructions about nipples.)

Never prop up the bottle and leave your baby to feed himself. The bottle can easily slip into the wrong position. Remember, too, your baby needs the security and pleasure it gives to be held at feeding time. It's a time for you and your baby to relax and enjoy each other. He/she should be held for bottle feedings as long as he/she is on the bottle.

The amount of formula your baby takes will vary. Babies have a right not to be hungry sometimes, and you cannot make a baby want to eat. Most babies feed for 15 to 20 minutes. The newborn generally takes from one-half to two ounces every three or four hours, gradually building up to three to six ounces by one month. When your baby takes all of his/her bottle, yet cries for more, or if he/she wants to feed every two hours instead of his/her usual three or four, then it is time to change the amount in each bottle.

A SCHEDULE WITH FLEXIBILITY:

Feeding schedules are usually most satisfactory if the hours are set roughly and the baby is allowed to eat when hungry.... for example, any time between three and five hours after the last feeding if formula fed, every two-three hours if breastfed. New babies usually need to be fed about every three hours to four hours. Should he/she occasionally wake up and cry less than two hours after a feeding, he/she is probably not hungry. However, should he/she consistently waken and cry less than two-and-a-half hours after feeding, the amount of formula or breast milk may be insufficient.

Remember your baby will cry for different reasons and may not necessarily be hungry. Though he/she will suck when given a bottle at this time, sucking is one way the baby has to soothe himself. Gradually, as you learn the difference between a hunger cry versus a mad cry or a wet or dirty cry, you will be able to mold baby's feeding times to fit your own needs.

"BURPING"

"Burping" your baby helps remove swallowed air. Even if fed properly, both bottle-fed and breast-fed babies usually swallow some air. The way to help your baby get rid of this is to "burp" or bubble him or her. Hold baby upright over your shoulder, and pat or rub the back very gently until he or she lets go of the air, or place him or her down over your lap and gently rub the back.

Your baby can also be "burped" by holding him or her in a sitting position (baby leaning slightly forward) on your lap, with your hand supporting the head.

It isn't always necessary to interrupt a feeding to "burp" your baby, but always do it after each feeding. Of course, sometimes your baby may not "burp" because he or she doesn't need to. So don't try to force him or her.

WATER:

Water is not necessary.

TEST BOTTLE NIPPLES REGULARLY:

Testing nipples regularly will save time when you're ready to feed your baby.

If nipple holes are too small the baby may tire of sucking before he/she gets all the formula he needs. If holes are too large the baby gets too much formula too fast, and may not get enough sucking to satisfy.

To enlarge holes that are too small, push a red-hot needle gently through from the outside. An easy way to prepare the needle is to put the blunt end in a cork and heat the sharp end in the flame of a match or cigarette lighter.

If nipple holes are too large, the nipple is worn out and should be thrown away.

Sometimes nipple holes become gummy. Place the nipples in a pan of water, add a pinch of salt, and boil for a few minutes.

VITAMINS:

Vitamins will be started according to your baby's needs. Infant formulas have vitamins added, so therefore vitamin supplementation is not needed. Following the AAP guidelined, we recommend that all breastfed babies receive vitamin D supplementation. Inadequate body stores of vitamin D can lead to a condition called nutritional rickets in which abnormal bone development can occur. Children at the greatest risk are those with darker skin, those who spend little time outdoors, solely breastfed infants, and older children who do not drink vitamin D fortified milk. You may use Polyvisol or Vidaylin drops that are available over the counter. The dosage is one dropper per day. Please talk to you doctor if you have more questions.

SUPPLEMENTAL FOODS:

The AAP recommends exclusive breastfeeding until 6 months to acheive full benefit of maternal antibodies and prevent food allergies. Formula or breast milk is nutritionally adequate for your baby until six months. An occasional infant becomes dissatisfied with breast milk or formula alone prior to three or four months of age. Please discuss supplemental feeding with the office nursing staff if you feel it is needed. Plain rice cereal diluted with water, formula, or expressed breast milk can be given once or twice daily, in amounts of one or two tablespoons, given with a baby spoon. Do not use a syringe or infant type feeder. These may be very dangerous and should not be used.

SKIN CARE

BATHING:

It's good to have a fairly regular time for bathing your baby. The room should be warm, with no drafts on baby. Keep bathing supplies together to save yourself steps. Until the navel (and circumcision) is healed, wash your baby by sponging. Afterwards you can use a tub or bathinette. Test the water temperature with your hand first. Daily bathing is unnecessary. We prefer Dove, or Basis instead of baby soaps or washes.

FACE: Wash with plain water and soft cloth and no soap.
EYES; To clean eyes, use plain water and a wash cloth.

EARS: Do not clean deeply because this packs the wax further back in the ear canal. Only wipe the outside of the ear with a moist cloth. If your baby seems to have an excessive amount of earwax, ask us what you should do.

HEAD: Lather the head with a "no tears" baby shampoo. The fontanels (soft spots) should also be washed. If flakes or greasy, scaly cradle cap develop, then you should gently scrub the head with a soft baby hairbrush or baby wash cloth. If the cradle cap persists, Cradle or Sebutone should be substituted.

VAGINA: Clean gently with plain water and a cotton ball. Use soap only if there is drainage or odor, and always rinse thoroughly. It is normal to see discharge or a drop of blood in the first few weeks of life. Wipe this area from front to back to avoid the introduction of stool into the urethra.

CIRCUMCISION: Clean with soap and water daily or as needed if soiled by stool. If there is mucus or blood drainage, petroleum jelly should be used to prevent sticking to diapers while healing.

NAVEL: Keep the diaper folded below the navel so that it can stay relatively dry. Apply alcohol to both the navel and the stump with a cotton tipped applicator four times daily until the cord falls off. Sometimes after the cord falls off there may be a few drops of blood, but this is no cause for worry.

DIAPER AREA: Change your baby's diaper as soon as possible after bowel movement or wetting. Wash with washcloth, soap and water, rinsing well and patting dry. You may use disposable diaper wipes, but they occasionally cause irritation. Wet gaute is an alternative. Normally, diaper creams are not necessary. If irritation occurs, do not use petroleum jelly, as it increases irritation. Powder should not be used as baby may inhale it. If needed, Balmex, Desitin or Triple Paste may be used.

SKIN PROTECTION: Lotion should be used sparingly only if skin is cracked or peeling. Eucerin, Cetaphil, Curel, Lubriderm, Moisturel, or Keri are recommended. All other creams, lotions, and oils are to be avoided. We do not recommend "baby" lotions, oils or powders.

HEAT RASH: (also called prickly heat.) This is largely avoided by not over dressing. Undershirts are seldom necessary and certainly not in the summer. Also, switching detergents, soaps, or diapers can sometimes cause rashes.

SAFETY:

You have already given your baby the very best care possible for months prior to his/her birth. Don't stop now! It is a Tennessee State Law that all infants be transported in proper child restraint devices. We strongly insist that the baby never be removed from the restraint seat for any reason while the car is in motion. We have a list of car seats recommended by the AAP in our office. You should never place your infant alone on a sofa, bed, or other high place unprotected. We see numerous accidents that have occurred while a baby is in a "walker" and we prefer that they not be used.

BABIES ARE BABIES

Although your baby will spend most of his/her day sleeping and eating, a number of other fascinating behaviors will also occur. All babies sneeze, yawn, belch, have hiccoughs, pass gas, cough, and cry. They may occasionally look cross eyed.

BREATHING: Babies have irregular breathing patterns, frequently panting rapidly, then stopping altogether for several seconds. Be reassured this is normal. This is called periodic breathing.

HICCUPS: These are spasms of the diaphram. They are harmless and do not cause pain for the baby. If they bother parents, give the baby a few swallows of warm water. This will usually stop them.

COUGHING: This is how the newborn clears the throat of mucus. Occasional coughs do not indicate a cold.

SNEEZING: This is how the baby cleans his/her nose of mucus and lint. Occasional sneezes do not indicate a cold. The baby's nose often seems stuffy during the first several months of life, especially if he/she is born in the fall or the winter. This is also due to trapped mucus partly blocking his/her very small nasal passages. A cool room and occasional use of a cool mist room humidifier will help.

PASSING GAS: This is always normal unless accompanied by severe pain or constipation (hard, infrequent stools). It is common for babies to be especially gassy for the first 1-2 months.

STOOLING: This occurs very often at first, frequently with each feeding, then gradually decreases with time. The first stools are black and smelly, changing by age two or three days to normal stools. A normal formula stool is yellow, brown, or green and mushy. A breast milk stool is loose, full of mucus and curds and is yellow or light brown. Formula babies stool from one to five times per day while breast-fed babies stool somewhat more often. Straining is normal. Unless stools are rock hard or are liquid, they are probably normal. Some babies do not stool every day but may go two or three days between stools.

SPITTING: All babies spit (or burp) some formula or breast milk from time to time. It decreases with age. During the first several days of life, the baby may normally spit up much phlegm or mucus that was not expelled during the delivery process. However, forceful vomiting is abnormal and should be reported to us. It is often helpful to keep your baby upright after feeding for 10-15 minutes.

SEEING: Newborns can see well enough to prefer watching a face or bright colors rather than blank walls. Occasionally, they look "cross-eyed". This is normal up to three months of age. If it persists after this time or if your baby does not appear to look with both eyes, be sure to mention this to the doctor.

HEARING: Most newborn babies prefer quiet environments. By 3 months of age you should feel that your baby hears you. Tell us if you can not be certain.

CRYING: Crying is the baby's way of saying he/she is hungry, wet, dirty, thirsty, hot, cold, sick, sleepy, or bored. You will gradually learn to know what your baby's different types of cries mean. Even a perfectly healthy baby will probably cry for a while each day without apparent reason. He/she do himself/herself no harm. As a matter of fact, the baby's crying time can equal up to 3 hours in a 24 hour period.

QUICK REFERENCE FOR COMMON ILLNESSES AND INJURIES OF CHILDHOOD

ILLNESS

During the first 3 months of life, it is especially important for you to recognize symptoms of illness in your infant; excessive irritability, refusal of feeding and, most importantly, a rectal temperature over 100.5 degrees. While your baby is young, to help prevent illness, it is advisable to avoid large crowds (malls, amusement parks, church nurseries). Washing hands prevents the spread of germs and should be encouraged before visitors hold your child. Persons who have colds or other illnesses should be asked to visit later when they are well.

JAUNDICE

Jaundice is a condition that commonly occurs in newborn infants. Jaundice is French word that means "yellow", and it describes the yellow color of the whites of the eyes and skin. Jaundice usually appears on the second or third day of life and often disappears in about a week. As many as two-thirds of infants may have jaundice because jaundice occurs when the liver is not fully mature. The liver ordinarily rids the blood of a substance called bilirubin. When new red blood cells are created, the old blood cells release a chemical known as bilirubin which is removed from the body by the liver. When the liver is not fully mature, it does not function properly and the bilirubin tends to build up in the baby's blood. Because bilirubin is yellow, it causes the skin to become yellow as well. This condition is known as jaundice. More serious types of jaundice can occur when the baby's blood type is different from the mothers. If jaundice is more severe or if the level of bilirubin gets too high, treatment will probably be necessary. A technique called phototherapy is used. Phototherapy is a treatment using florescent lights. These lights cause a chemical reaction to occur that hastens the removal of bilirubin from the body. These high intensity florescent lights are placed over the baby. The baby is kept warm and has protection from the lights over his/her eyes. This is done either in the hospital or by special arrangement with a home health nurse. Sunlight or the fluorescent lights you have a home DO NOT HAVE enough of the correct intensity to help lower the bilirubin level. The phototherapy is continued until the bilirubin drops to a safe level. The level is checked by testing a sample of blood. For reasons that are unclear, excessive jaundice sometimes occurs in breast-fed babies. If your baby is even slightly jaundiced at the time of discharge, we require you to come back to the office in a day or two to have a bilirubin level checked. If the level has risen significantly, this may mean that the baby must be receive phototherapy, which can usually be done at home.

MANAGEMENT OF FEVER

Fever is a symptom, not a disease. It is usually a sign of infection. Fever is part of your child's defenses against infection, helping to "burn out" the germ causing the infection.

When your child has an infection, antibiotics may be required (but only if the infection is caused by bacteria). Fever is more often caused by viruses than by bacteria.

Infants and children frequently get temperature elevations as high as 104 degrees Fahrenheit (40 degrees Centigrade). This degree of fever is not harmful in itself and is **NOT** a medical emergency.

Temperatures taken by ear probes such as Thermoscan are not as reliable and we urge you not to use them. Digital thermometers such as Bard Parker are inexpensive and are very accurate. The most accurate temperature is taken **rectally** and is reliable after three minutes by a mercury thermometer or after the beep digitally. An axillary temperature (taken high up in the child's armpit) requires five minutes for mercury thermometer or until the beep digitally and is not as reliable. The oral (mouth) temperature also requires three minutes by mercury thermometer with the thermometer placed under the tongue and the mouth closed. It is best used only in children over four years of age. It is inaccurate if liquids have been taken recently, whether hot or cold.

When reporting fever to our nurses or doctors, please **DO NOT** add or subtract degrees because this is very confusing. Just be sure to take the temperature accurately and report which method was used.

If your child has a fever, there are several things you can do to help relieve discomfort.

1. Give plenty of cold fluids (juices, Coke, 7-Up, Sprite, popsicles, Jell-O, tea, ice chips, etc.) Appetite for food is usually decreased with fever but should improve when the child begins to feel better.
2. Dress your child lightly and remove all tight fitting clothing. Bedclothes should also be light.
3. Fever reducing agents (acetaminophen or ibuprofen) can be used. Remember that your child will usually have a fever for 2-3 days with most illnesses even if antibiotics and other measures are used. After your child has been examined by the doctor and treatment has begun, if he/she becomes quite ill with difficulty breathing, extreme sleepiness, severe vomiting or other symptoms not anticipated by the doctor, we should be notified again.

   We do not recommend aspirin with fever due to the possibility of developing Reye's syndrome.
4. If the fever is over 104 degrees, in addition to fever reducing analgesics, you can sponge with water that is lukewarm (neither hot nor cold). Rub skin briskly with a washcloth, especially in the area of the armpits, back and groin or place the child in a tepid bath. We do not recommend bathing with alcohol.
5. **REMEMBER, acetaminophen and ibuprofen can be dangerous so return bottle to a safe place and don't exceed the recommended**

dosage of acetaminophen or ibuprofen.

YOU NEED TO CALL OUR OFFICE DURING REGULAR OFFICE HOURS IF:

1. Your child seems very ill.
2. Fever continues for more than 24 hours and your child has not been examined in the office.
3. Fever of any degree if your child appears very ill and has not been examined in the office.

YOU NEED TO CALL AT ANY TIME IF:

1. Your child is less than 3 months old and has a rectal temperature greater than 100.5 degrees F. and has not been seen by the doctor.
2. Fever of greater than 105 degrees F. and has not been seen by the doctor.
3. Your child is extremely irritable and cannot be consoled.

ACETAMINOPHEN

Acetaminophen is a powerful analgesic and good fever reducing agent. It is very safe if used properly. In order for you to use acetaminophen safely, you should be familiar with the following terms:

- A milliliter (ml) equals one "cc" and is a measure of volume.
- A milligram (mg) is a measure of weight.
- One teaspoon is 5 ml or (5cc).
- One-half teaspoon is 2.5 ml or (2.5cc).
- One-quarter teaspoon is 1.25 ml or (1.25cc).
- Drops are more concentrated, i.e., have more drug per volume than elixirs or suspensions.

Because there are so many different forms of acetaminophen, we recommend that you purchase only Tylenol products, thereby eliminating any confusion with the other forms of acetaminophen.

We also urge you NOT to use combination products containing cold and cough medicines combined with either ibuprofen or acetaminophen.

Generally, acetaminophen has fewer side effects than ibuprofen, so we prefer that you use it in preference to ibuprofen in most circumstances.

ACETAMINOPHEN/TYLENOL

PRODUCT?	WHICH BOTTLE/ PACKAGE SIZE?	WHICH FLAVOR?	ACTIVE INGREDIENTS	DIRECTIONS: AGE	WT	DOSE
INFANT'S TYLENOL SUSPENSION DROPS	PHYSICIANS DO NOT RECOMMEND					
CHILDREN'S TYLENOL SUSPENSION LIQUID ORIGINAL	SUSPENSION LIQUID 2 OZ. 4 OZ. 4 OZ. 4 OZ.	CHERRY CHERRY GRAPE BUBBLEGUM	160 mg acetaminiphen per 5 ml (1 teaspoon)	4-11 mos 12-23 mos 2-3 yrs 4-5 yrs 6-8 yrs	12-17 lbs 18-23 lbs 24-35 lbs 36-47 lbs 48-59 lbs	½ teaspoon ¾ teaspoon 1 teaspoon 1 ½ teaspoons 2 teaspoons
ELIXIR	ORIGINAL ELIXIR 2 OZ. 4 OZ. 16 OZ.	 CHERRY CHERRY CHERRY		9-10 yrs 11 years	60-71 lbs 75-95 lbs	2 ½ teaspoons 3 teaspoons
CHILDREN'S TYLENOL CHEWABLE TABLETS	BOTTLES OF: 30 30 30 BLISTER PACKS 60 90	 BUBBLEGUM GRAPE FRUIT BURST FRUIT BURST FRUIT BURST	80 mg acetaminiphen per tablet	2-3 yrs 4-5 yrs 6-8 yrs 9-10 yrs 11 years	24-35 lbs 36-47 lbs 48-59 lbs 60-71 lbs 72-95 lbs	2 tablets 3 tablets 4 tablets 5 tablets 6 tablets
JUNIOR STRENGTH TYLENOL CHEWABLE TABLETS	CHEWABLE TABLETS BLISTER PACKS 24 24	 FRUIT GRAPE	160 mg acetaminiphen per tablet/caplet	6-8 yrs 9-10 yrs 11 yrs 12 yrs	48-59 lbs 60-71 lbs 72-95 lbs 96 lbs & over	2 tablets/caplets 2 ½ tablets/caplets 3 tablets/caplets 4 tablets/caplets
SWALLOWABLE CAPLETS	COATED CAPLETS BLISTER PACKS 30					
ADULT STRENGTH TYLENOL	ASSORTED SIZES AVAILABLE		325 mg acetaminiphen per tablet	11 yrs & older	96 lbs & over	2 tablets

IBUPROFEN

Ibuprofen is a powerful analgesic, fever reducing agent and anti-inflammatory medication. Since it can cause abdominal pain, vomiting and occasional problems with urinary function, we prefer that it be used only for very high (> 104^0) or persistent fever. We also use ibuprofen for athletic injuries, arthritic, and muscular pain.

Ibuprofen is relatively safe if used properly. In order to use it safely, you should be familiar with the following terms:

- A milliliter (ml) equals one "cc" and is a measure of volume.
- A milligram (mg) is a measure of weight.
- One teaspoon is 5 ml or (5cc).
- One-half teaspoon is 2.5 ml or (2.5cc).
- One-quarter teaspoon is 1.25 ml or (1.25cc).
- Drops are more concentrated, i.e., have more drug per volume than elixirs or suspensions.

Because there are so many different forms of ibuprofen, we recommend that you purchase only Motrin products, thereby eliminating any confusion with the other forms of ibuprofen.

We also urge you NOT to use combination products containing cold and cough medicines combined with either ibuprofen or acetaminophen.

Generally, acetaminophen has fewer side effects than ibuprofen, so we prefer that you use it in preference to ibuprofen in most circumstances.

IBUPROFEN/MOTRIN

PRODUCT?	WHICH BOTTLE/ PACKAGE SIZE?	WHICH FLAVOR?	ACTIVE INGREDIENTS	DIRECTIONS: AGE	WT	DOSE
CHILDREN'S MOTRIN ORAL DROPS	PHYSICIANS DO NOT RECOMMEND					
CHILDREN'S MOTRIN ORAL SUSPENSION LIQUID	2 OZ. 4 OZ.	BERRY BERRY	100 mg ibuprofen per 5 ml (1 teaspoon)	00-06 mos 06-12 mos 1-2 yrs 2-3 yrs 4-5 yrs 6-8 yrs 9-10 yrs 11 years	<15 lbs 15-20 lbs 18-23 lbs 24-35 lbs 36-47 lbs 48-59 lbs 60-71 lbs 75-95 lbs	DO NOT USE ½ teaspoon ¾ teaspoon 1 teaspoon 1 ½ teaspoons 2 teaspoons 2 ½ teaspoons 3 teaspoons
JUNIOR STRENGTH MOTRIN SWALLOWABLE CAPLETS (for ages 6-11)	COATED CAPLETS: 24 48		100 mg ibuprofen per tablet	6-8 yrs 9-10 yrs 11 years	48-59 lbs 60-71 lbs 72-95 lbs	2 tablets/caplets 2 ½ tablets/caplets 3 tablets/caplets
ADULT STRENGTH MOTRIN	TABLETS & CAPLETS 24 50 100 130 150		200 mg ibuprofen per tablet	12 yrs & older	96 lbs & over	2 tablets

UPPER RESPIRATORY INFECTIONS

Upper respiratory infections (common colds) are caused by viruses and usually last 7-14 days. There are well over 100 viruses that cause colds, and children average up to 8 colds per year. If there are smokers in the home or the child is in day care, colds may occur more often. Colds are spread from one person to another through air or by direct contact. They have a variety of symptoms including sneezing, runny nose, cough, mild sore throat, malaise (tiredness) loss of appetite and fever. If present, a fever usually occurs the first two days and is rarely over 102.5 degrees.

ANTIBIOTICS are not helpful for the resolution of cold symptoms. Nasal dreanage from colds may range from clear yellow to green in color and should go away in 7-10 days. Yellow or green mucus does not mean your child has a bacterial or sinus infection.

TREATMENT:

There is not a medication that will shorten the duration of a cold (make it go away). Therefore, treatment is aimed at helping the child feel better. It is best to avoid most medications if the child is not very ill. They usually do not work well, and all have potential side effects which are worse that the cold itself. Plenty of fluids and rest, saline nose drops, suctioning infants' noses with a bulb syringe, using a cool mist vaporizer to loosen nasal secretions, and elevating the head of the bed will help your child feel better. (Vaporizers should be cleaned every 3 days to prevent growth of mold. Follow manufacturer's directions for cleaning.)

ACETAMINOPHEN (Tylenol, Tempra, Panadol) helps the child feel better whether or not a fever is present. If a child is less than 3 months old and fever over 100.5 degrees is present, contact our office. We do not recommend the use of aspirin due to the possibility the child may develop Reye's Syndrome.

ANTIHISTAMINES will not cure a cold but may produce a slight reduction in nasal secretions. They do cause drowsiness. Common antihistamines include: chlorpheniramine (found in orange Triaminic, Chlortrimeton, Sudafed, or red Pedicare), brompheniramine (found in Dimetapp or Bromfed) and diphenhydramine (found in Benadryl).

DECONGESTANTS may reduce nasal congestion, but they may cause irritability and sleeplessness. Pseudoephedrine (found in many cold

preparations) is the most widely available decongestant. Topical Decongestants such as Neo-Synephrine nose drops have a significant rebound effect (ultimately making nasal congestion worse) and are not routinely recommended.

EXPECTORANTS have no proven medical benefit and are not needed. But guafenesin, the most common, is found in many cold preparations.

COUGH SUPPRESSANTS may be used at night to minimize cough from colds. Common cough suppressants include: dextromethorphan (found in Robitussin or the DM in many cold preparations) or diphenhydramine (found in Benadryl).

COMPLICATIONS:

EAR INFECTIONS are the most common complication of colds and may be accompanied by prolonged fever (greater than 48 hours), extreme fussiness, difficulty with sleep, or ear pain. Bacterial ear infections do need to be treated with antibiotics and should be seen by the doctor.

CONJUNCTIVITIS (pink eye, cold in the eye) may occur as part of a cold. If the drainage is only minimal, the conditions may be observed and not treated; however, if the drainage becomes very thick, and occurs all day long (not just after sleep time) or persists longer than 5 days, antibiotic eye drops are usually needed.

BRONCHITIS is an infection of the bronchial tubes and is another complication of a cold. Cough is prominent and may be accompanied by wheezing or shortness of breath. Fever may also occur. Bronchitis can be either viral or bacterial and does require being seen by a doctor.

PNEUMONIA is a rare complication of a cold. It is an infection in the lungs and is usually accompanied by a very high fever (104 degrees), problems with breathing, and extreme lethargy (difficulty staying awake). Children are usually very ill when they have pneumonia; they do not merely have a deep cough. Pneumonia requires prompt treatment by a physician.

SORE THROATS may occur because of post nasal drip. If tonsils are enlarged or if other unusual symptoms develop, the sore throat may be the result of the strep germ. The child would need to have the throat cultured and evaluated by a physician.

SINUS INFECTIONS sometimes occur after a cold and usually have prolonged nasal congestion (greater than 2 weeks), cough, or malaise (tiredness). A THICK GREEN RUNNY NOSE IS NOT NECESSARILY AN INDICATION OF A SINUS INFECTION. IN FACT, IT IS USUALLY A PART OF THE NATURAL RESOLUTION OF A COLD.

SUMMARY:

Call our office when your child exhibits any of the following:

a. cold symptom and the child feels very ill
b. ear pain
c. difficulty breathing or chest pain
d. temperature greater than 102 degrees that does not respond to acetaminophen or temperature that develops in the latter stages of a cold
e. cold symptoms that last longer than 7-14 days
f. symptoms of dehydration (decreased urination, concentrated urine, pale skin. weakness, dry lips and tongue, decreased drinking or decreased tearing)

CROUP

Croup is a contgious viral infection which attacks the vocal cords and is usually accompanied by cold symptoms. It is usually worse in the middle of the night and is more serious in young children less than 2-3 years old. A croupy cough sounds like a barking dog or a seal. Croup may last as long as a week, but symptoms are often worse the first few nights. The swelling around the vocal cords produces the harsh, barky cough. The swelling may worsen and cause problems with breathing (stridor). Treatment is aimed at reducing the swelling:

1. Cool Air - either cool night air or with a cool mist vaporizer. Even standing in front of the freezer for 5-10 minutes may help.
2. Moist Air - either with a cool mist vaporizer or a steamy bathroom (close the bathroom door, turn on the hot shower and steam up the room).
3. Cool Liquids

If your child is still gasping for air after 10 minutes in a steamy bathroom followed by 10 minutes of very cold air, proceed immediately to East Tennessee Children's Hospital Emergency Room. Seat your child in the car in front of an air conditioning vent. Do not place your child in the front seat if your car has a passenger air bags.

VOMITING AND DIARRHEA (ACUTE GASTROENTERITIS)

Vomiting and diarrhea are common problems in infants and young children. These symptoms are usually caused by viruses and are usually self limited if cared for appropriately, i.e. they do not need to be treated. Vomiting normally lasts 24-48 hours and diarrhea 1-2 weeks. However, if any of the following problems are also present, you should contact our office for further instructions:

1. Fever over 102 degrees F. which does not respond to acetaminophen or which recurs for more than 24 hours.
2. SEVERE abdominal (stomach) pain or cramps.
3. Pain other than in the abdomen.
4. Blood in the stools or vomitus.
5. Signs of dehydration; decreased urination (longer than 6-8 hours), concentrated urine, pale skin, weakness, dry lips and tongue, decreased drinking or decreased tearing.

If none of the above are present, FOLLOW THESE INSTRUCTIONS:

1. Nothing by mouth for 1-2 hours after the onset of vomiting or frequent diarrhea (more than 5 times a day). If significant vomiting persists call the office for further instructions.
2. Then give ONLY clear liquids (no solid food, no milk, no orange juice nor plain water) until vomiting has stopped for 6-12 hours. Begin in small amounts; one ounce every 15-20 minutes increasing the amount very slowly.

Here are some clear liquids to try:

For Infants:

A. Pedialyte
Ricelyte
Infalyte
Breast fed infants may continue to nurse

For children 4-6 months, in addition to the above:

B. 7-Up
Dr.Pepper
Sprite
Ginger Ale
Coca-Cola
Gatorade

C. Broth
Popsicles
Jell-O
Kool-Aid
Apple Juice
Weak Tea

3. After 8-12 hours without vomiting and lessened diarrhea (less than 7 stools per day) begin the following:

D. Bananas
Rice or Rice-cereal
Crackers
Applesauce
Toast (dry)

E. Dry baked or boiled potatoes
Cottage Cheese
Boiled or poached eggs
Yogurt
Dry cereal
Pasta

F. Baked or broiled fish, chicken or turkey.
Lean baked or broiled red meat.
Carrots.

4. Do Not Give fried, greasy, spicy or fatty foods or orange juice for 3 or 4 days after the diarrhea has cleared.

5. Stools may remain small, green, poorly formed and with mucus for 1-2 weeks. If they number less than 5 per 24 hours, you can continue to advance the diet.

INJURIES

CUTS AND SCRAPES:

Clean as soon as possible with soap and large amounts of water. Dry with a clean cloth and apply an ointment like Neopsorin or Betadine.

If the cut is still bleeding after cleansing, apply firm pressure. If the edges of the cut gape open or bleeding persists, stitches are probably necessary. Sutures must be done within 8 hours of the cut. We suture in our offices but after hours refer our patients to the Emergency Room at East Tennessee Children's Hospital. Following a deep cut, if your child has not had a tetanus shot within the last 5 years, it should be given within 48 hours.

Watch for infection as the cut heals. We need to check the cut if there is any marked redness, soreness or pus.

BUMPS, BRUISES AND BROKEN BONES:

Ice will reduce swelling and should be applied immediately. If the area is very large, very tender or results in the inability to move an arm, leg, finger or toes, we need to check for a fracture. If you suspect a broken bone, splint gently with a newspaper or board. We are able to evaluate fractures in our office, but after hours, we recommend the Emergency Room at East Tennessee Children's Hospital.

BURNS:

Apply cold water or ice immediately. If the area is extensive, we need to evaluate or if it is after hours, we recommend the Emergency Room at East Tennessee Children's Hospital. Smaller burns can be treated at home with cleansing with soap and water followed by an application of an ointment like Neosporin or Betadine. The burn should be covered with a clean, dry bandage. Do not purposefully puncture blisters as this could lead to infection. Severe pain, excessive redness or pus could mean infection and we need to evaluate these burns in the office.

POISONING:

Poison Control: 1-800-222-1222

Call our office or Poison Control immediately for instructions. Never induce vomiting unless you have been specifically instructed to do so. Vomiting can make the situation much worse with some poisons.

HEAD INJURY

Most head injuries require either phone consultation or examination. Any person receiving a blow to the head may have injury to the brain or small blood vessel which is not always evident on x-rays immediately following the accident; therefore, it is important to observe your child closely during the 48 hours after a head injury and telephone us should any of the following signs of trouble develop.

1. Loss of consciousness, even if only for a short time.
2. Vomiting.
3. Double vision.
4. Persistent dizziness.
5. Severe headache, not relieved by Tylenol.
6. Excessive Drowsiness.
7. An obvious depression in the skull.

POST-HEAD INJURY CARE: If none of the above have occurred, the child can be observed at home and may be allowed to sleep for up to two hours. Then the child should be awakened and checked by observing his or her balance during walking, understanding of commands (e.g., "John, go to the kitchen and get a spoon"), and general appearance.

For an infant, observe to see that the child is alert, follows a brightly colored object with his or her eyes, and has normal movement of both sides of the body. Your child should continue to be awakened every two to three hours for twelve hours after the injury. It is not uncommon to have mild headaches for several days after a head injury. If you are uncertain of the child's status, call the office for further advice.

When your child has a head injury, be sure you have had all of the signs of danger explained to you and that all of your questions have been answered.