Parent's Survival Guide

Mercy Kids

Every child. Every need. Every day.

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The safety of our patients and caregivers has been, and always will be, our priority. We follow strict standards for disinfecting, required masking for patients, visitors and co-workers, and social distancing.

Please do your part by following these and other CDC guidelines.

Parent's Survival Guide

Being a parent can be humbling. One day you feel like you have things under control, and the next day you feel completely overwhelmed. It helps to have advice from trusted experts along the way. Mercy Kids has compiled a set of articles on parenting to help you meet some of these challenges head-on.

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Top 5 Questions Asked by Parents of a New Baby

Leaving the hospital with a newborn can be scary. You're now totally responsible for another life, another person. With this fear often comes a list of questions commonly voiced at the first office visit. Below are five of the most common topics of doubt and worry.

How do I breastfeed?

In the first 48 hours of life, infants are usually very sleepy. It's hard to get them to the breast and hard to keep them awake. Starting on the third day of life, most become more alert and hungrier. Because most first-time moms produce colostrum for the first 96 hours, many infants are very demanding on days three and four. The secret of good breastfeeding is to ensure a good latch with the help of experienced nurses and lactation consultants in the first 48 hours. Put baby to breast every two to three hours. Most infants feed better at night so keep baby in the room, but not co-sleeping in your bed at night. Avoid bottles and pacifiers for the first week or two. A weight check is the best way to measure feeding, so baby should see his pediatrician within two days after coming home.

How much should my baby sleep?

Infants sleep most of the time, up to 20-21 hours daily, for the first one to two months. While not ideal for parents' sleep habits, newborns are more active and alert in the middle of the night, usually sleeping better during the day. Most newborns sleep best when swaddled tightly enough that they cannot pull their arms out of the blankets. The average age for sleeping through the night is four to six months.

Will my baby get colic?

Colic usually happens around three weeks with inconsolable crying lasting several hours most evenings, followed by normal behavior the next day. Colic rarely has any identifiable cause and no cure. It peaks by six weeks and goes away by three months. Colic can sometimes be relieved by reducing stimulation to your baby. Keep the room dark and quiet. Consider swaddling.

Does my baby have reflux?

Most babies spit up, and most are not bothered by it. Spitting up peaks at around four to five months. The best thing parents can do is keep towels, burp cloths and changes of clothes handy. A small percentage of babies have pain with reflux and a small number of those are helped with medicine or diet changes.

How do I care for the circumcision?

Circumcisions are done in different ways. With the plastic ring, no special care is needed other than cleaning it off with diaper wipes or water when dirty. When the foreskin is cut off, apply greasy ointment (like A&D®) to the head several times per day for a week. Regardless of type, after it is healed it's important to make sure the skin is pulled back at least once a day so there is no reattaching. For non-circumcised infants, no special care is needed.

Joseph Kahn MD, President Mercy Kids, is a pediatrician with more than 35 years of experience caring for newborns.

Childhood Constipation

We, as a society, pay considerable attention to what goes into and comes out of our bodies and the bodies of our children. When there is either too little, infrequent or painful passage of stool, it's termed constipation. However, not every child who hasn't eliminated for a day is constipated. In children, fortunately, most causes of constipation are temporary. Simple dietary adjustments — eating more fiber-containing fruits and vegetables and drinking more fluids — usually help. In some cases, laxatives can also help.

Symptoms of childhood constipation may range from absence of bowel movements for a few days to vomiting, crankiness around stool times, abdominal pain and/or internal swelling. Some red flags to keep in mind are poor weight gain, a tender belly, painful cracks at the anal opening (fissures) or a swelling/protrusion at the anus.

Constipation comprises 10-15 percent of pediatrician visits and up to 25 percent of pediatric gastroenterology practice. In our patient population, the most commonly seen cause of constipation is "withholding," a behavior where children may lay on the floor stiff, cross their legs, or hold on to the toilet seat to avoid painful elimination. This behavior may begin with early toilet training, diet or routine change, medications or school bathroom avoidance. A subset of kids in the following categories also may be especially at risk for constipation: kids who are sedentary/obese, those not getting enough fiber or fluid, those on medications for depression/ADHD or children with abnormalities of the rectal area. Therapies will depend on the underlying disorder in these cases.

Treatment of constipation is fairly simple, but requires consistency and attention to "intake" and "output." Teaching children to follow the body's "pooping signals" is very important in the long-term success of any regimen. Most physicians recommend a combination of a stool softener, a lubricant and a mild stimulant. These can result in soft, pain-free stools that decrease the child's fear of eliminating.

The long-term consequences of untreated constipation in children include colonic distention and stretching that may lead to stool leakage (encopresis), urinary tract infections from rectal pressure, chronic abdominal pain, missed school days, and the psycho-social effects of the above on normal childhood behavior and development. The bottom line is that bowel movements should be easy and natural. Your Mercy pediatrician is always available to discuss these issues further.

Amana Nasir, MD, is a pediatric gastroenterologist with Mercy Children's Hospital.

How Sick is Too Sick for School?

The school season doesn't just bring new clothes, backpacks and classrooms. It also creates a whole new dilemma for parents. School is a great place for germ sharing. If it hasn't happened yet, it won't be too long before you're awakened by the whiny refrain of, "I don't feel so good," and the dreaded question: **"Is my kid too sick for school?"**

It's always useful to rely on a few trusted instincts. In general, a healthy dose of common sense and a genuine concern for the well-being of your child will generally lead to the right decision. The American Academy of Pediatrics suggests keeping your child home if:

- The child has a fever
- The child is not well enough to participate in school activities
- The child may be contagious to others

Let's review a few common scenarios.

Fever

If your school-aged child has a temperature of 100.5 F or greater, he's considered contagious and should remain home. With a fever, he's most likely pretty uncomfortable and won't be able to learn or participate in class (just think how you feel with a fever). Your child should remain home until he's been fever-free for 24 hours.

Cough and Cold Symptoms

Most of the time, upper respiratory infection symptoms are more of a nuisance and don't necessitate your child staying home (otherwise, schools would be empty!). Colds typically last three to seven days; the age-old adage of "Tincture of Time" is all we can prescribe. If symptoms interfere with her ability to participate in school, such as a cough keeping her up all night, then keep her home for some TLC.

Diarrhea and Vomiting

If your child has active symptoms of diarrhea or vomiting, then he's too sick and contagious to go to school. A good rule of thumb is to keep him home until he's had no more episodes of vomiting or diarrhea for 24 hours. The tricky part comes when he has the persistent, lingering soft stool. Consult your doctor and use his comfort level in deciding.

Sore Throat

If she doesn't have a fever and can tolerate eating and drinking, she's probably okay for school. However, if she's been diagnosed with strep throat, she'll need 24 hours of antibiotics before returning to school.

Pink (Red) Eyes

If his eyes are red, covered in — or oozing — yellow/green discharge, then you're likely dealing with a contagious case of conjunctivitis (the dreaded pink eye). Again, he'll need 24 hours of antibiotics before returning to school. On the other hand, slightly pink eyes with clear/watery discharge is likely caused by allergies. He's okay to be at school.

Rashes

Rashes have many different causes, and may require a doctor's diagnosis. Some are contagious before the rash appears. Others, like chickenpox and hand, foot and mouth disease will keep the child home until the sores are crusted over.

Remember: trust your instincts. Your child's well-being comes first. If all else fails, your doctor is always only a phone call away to help you navigate these difficult decisions.

Diana M. Roukoz, D.O. is a Mercy Kids pediatrician with Mercy Children's Hospital

Is My Kid Weird?

Parents have a lot of things to worry about. Worrying about whether or not their kid is weird shouldn't be one of them.

Parents often come to me hanging their heads in shame for some of the things their kids are doing. It's part of my job to ease their minds. Their kid is not the first to eat things that the earth provides, like dirt, rocks and leaves. Their kid is not the first to test what size toy parts will fit up their nostrils or use the vacuum hose to create colorful body art (known as "hickies" to the younger crowd). Kids are also known to head-butt walls because they find it soothing, sleepwalk (a book chapter in itself about weirdness at its most unconscious level), forget to wear underpants, urinate outdoors and touch themselves inappropriately in public.

Kids just do weird things. It's a part of growing up.

What parents do need to watch out for is what they're putting in their mouths. While those things from the earth will run their natural course, other things are dangerous. Lock up the medicine cabinet. Keep batteries, small magnets and household chemicals far from reach, too.

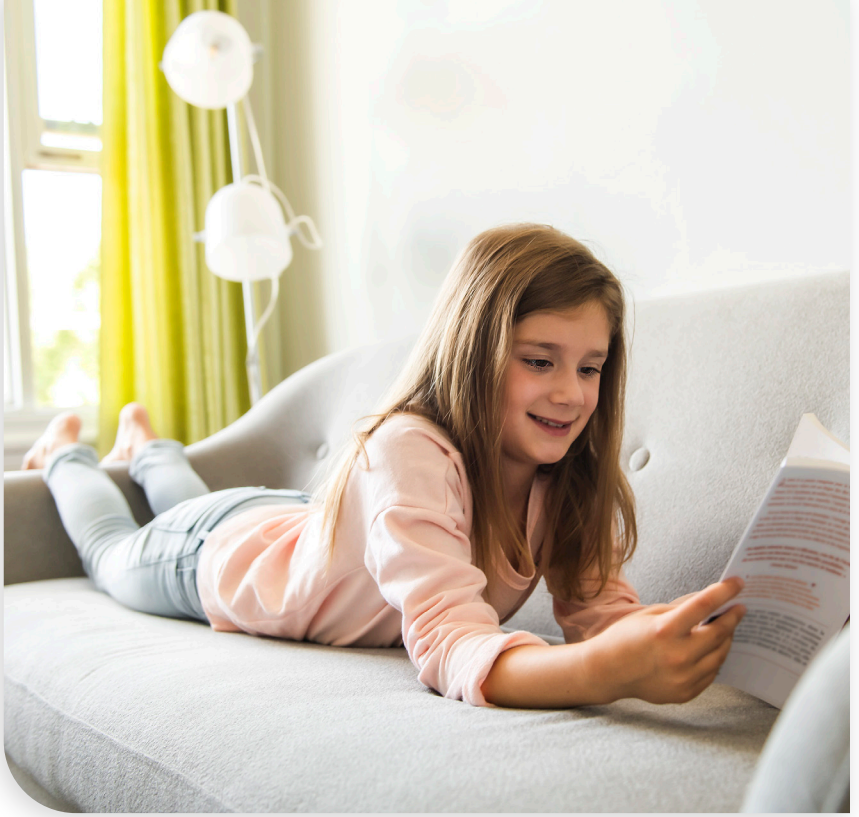
Sometimes big changes stir up new behaviors. An only child who gets a new sibling may act out in weird ways to attract attention away from the baby. An easy fix is to put aside time to do things with just the older child and also allow her to help you take care of the baby.

So the next time Billy picks his nose, let him know that's not something we do in public. If Sally stutters, let her gather her thoughts and get through the words in her own time. If it's a behavior that can be ignored, ignore it. As long as the behaviors are not dangerous, not having a disparaging effect at home or school and aren't serious cries for attention, it's probably temporary.

Kids of all ages, from babies to school-aged children, go through periods of what adults may call weirdness. Most kids grow out of it. Of course, if you do have concerns, it always helps to talk to your child's pediatrician. We can help put your mind at ease and offer some direction if you need it.

When you think about it, though, a little weirdness is bound to come out of curiosity, new encounters, lightheartedness and just plain not knowing the difference. Those are qualities about kids that make childhood magical. Enjoy it as long as you can, even if it may seem a little weird at times.

Douglas Durand, MD, is a Mercy Clinic pediatrician in Washington, MO, and part of Mercy Children's Hospital.



Home Alone for the First Time

The idea of staying home alone changed forever after the Home Alone movies of the 90's. And while Kevin's challenges were a little more dramatic than those your kids will face, it's important for your children to know what to do when they're home alone.

Leaving your child home alone is a big step, and it's natural to be anxious. You might wonder what age is appropriate, what is the right length of time, and what your kids should know before you take that step.

There are really no laws on the books about the correct age. You'll need to make a judgment call based on what you know about your child. All kids mature at different paces, so consider not only your child's age but how he responds to various situations. My general recommendation is by age 10 or 11, most kids are ready for a trial run. Keep in mind — just because your child may stay home alone doesn't mean he's ready to watch other kids.

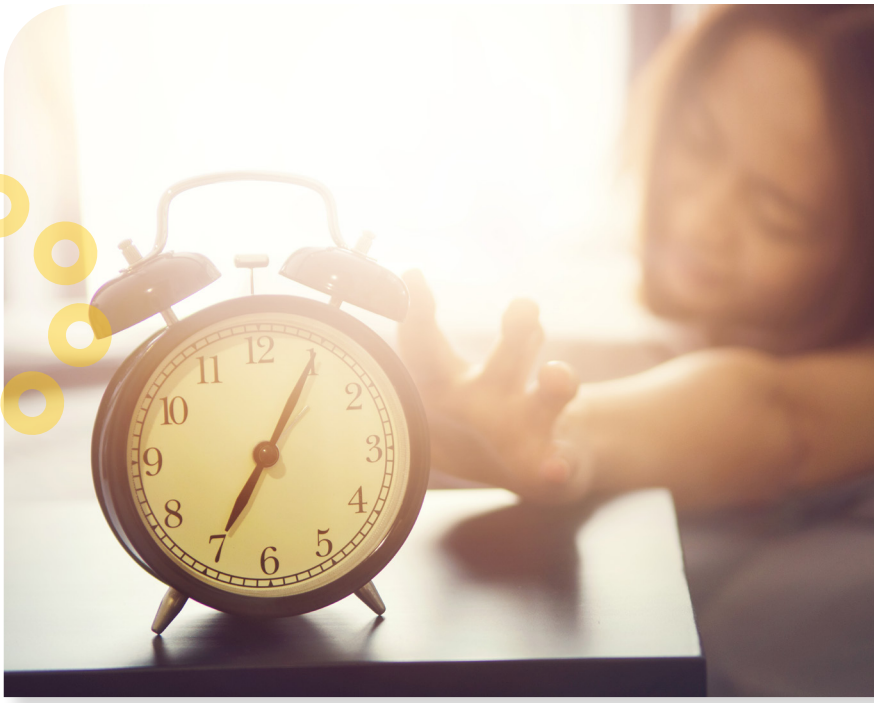
When learning about safety, kids need to know what to do in different scenarios and have clear-cut rules. Should he open the door if someone knocks? What if it's the adult neighbor she knows? Or a delivery man with flowers? Should she answer the phone? What about making snacks using the microwave or oven?

Here are some good tips to keep handy if you're considering leaving your kids home alone:

- Identify a contact person nearby who can be reached, if needed.
- Give kids their own key to keep in their bags or a safe place. (Hidden keys are never safe and if the garage keypad is relied upon, there's always a chance of power outage.)
- Leave an extra key with a trusted neighbor who will be home.
- Always keep the doors locked and don't open them for anyone.
- Discuss how to handle phone calls — whether to screen them or just not answer.
- Review basic first aid and keep an emergency kit in a convenient place.
- Review what to do in case of an emergency, including how and when to call 9-1-1.
- Show your child a safe place to go during a thunderstorm, tornado or earthquake.
- Discuss a fire safety plan — two ways out of every room in case of fire, as well as not using or playing with matches, stoves, appliances or fireplaces.
- Make a special grab-bag with games, videos or crafts to keep busy.

Finally, remind your children that they must show responsibility to be able to stay home alone. It's a privilege to be earned.

Julie Eldridge is a pediatric educator at Mercy Children's Hospital.



Back to School, Not Back to Snooze

A new school year often brings a lot of excitement as well as adjustments in routines for parents and children alike. One major adjustment, especially for teenagers, is the early start times of school.

Typical teenagers are night owls — they like to stay up late and sleep late. That routine becomes a problem when school starts. In short, their "social clock" is not the same as their biological clock, and they might feel jet-lagged.

Teenagers generally require nine hours of sleep a night, but they often don't get the full amount, leaving them feeling tired, unmotivated and irritable. Lack of sleep affects classroom participation as well, especially in early morning classes.

If not addressed, this may lead to chronic sleep deprivation resulting in errors in judgment, aggression, vehicular accidents, behavioral difficulties, poor academic performance and various medical problems. It's therefore essential to prepare for the new schedule well in advance with simple interventions at home.

First of all, ensure your teen is getting adequate sleep every night (count only hours spent sleeping). Decide a fixed wake time depending on the school schedule and stick to it. Gradually shift the bedtime by about 30 minutes every three to four days, giving enough time to adjust to a new schedule. Your teen will probably feel tired for the first few days, but resist the temptation to take daytime naps.

Practice good "sleep hygiene" such as:

- Starting a calm bedtime routine
- Avoiding caffeine in the evening
- Cutting down on screen time (phone, video games, TV, computers) at least an hour before bedtime
- Waking up at a consistent time
- Not sleeping in more than an hour on weekends

It takes about two to three weeks to change the biological rhythm with earlier bed time and stable wake time. On rare occasions, the problem continues despite behavioral interventions, and your teen may need a thorough sleep evaluation, further schedule adjustments, and short-term medication management.

In the majority of cases, a good mix of motivation, scheduling and support is all it takes to successfully get back to school without hitting that snooze button every morning.

What to Do If Your Child Has Sleep Problems

One in three children and adolescents experiences sleep problems. Common sleep issues include bedtime refusal, frequent awakenings, daytime sleepiness, nightmares and sleepwalking. These children may be irritable, less successful in school and more prone to injury. Parents often become frustrated and lose sleep themselves trying to help.

How to deal with this problem? To start, set realistic sleep expectations. If your child is getting too much sleep during the day — such as naps in the car — he may wake frequently or have sleep refusal. Discuss appropriate sleep requirements and schedule with your pediatrician.

Partial awakenings — times when a child enters a light sleep from a deeper sleep — are normal. The child may open his eyes but resumes a deeper sleep once he recognizes a familiar environment. This is especially common among babies at six to 12 months. To prevent problems from developing, let children fall asleep by themselves in the familiar surroundings of their crib or bed. Parents should not disturb them during partial awakenings.

Children who develop an association between sleep onset and activities like being held, rocked, fed or watching television commonly have frequent awakenings. The actual problem, though, is not spontaneous awakenings during the night, but the child's inability to resume sleep on his own in the absence of the transitional activity. Children must be conditioned to a new sleep association habit that requires putting them to bed while still awake.

Many toddlers are reluctant to go to bed. They're afraid of missing exciting events, or simply prefer not to be left alone. However, inconsistent bedtime rules confuse toddlers and may result in bedtime refusal and nighttime awakenings. A predictable, non-stimulating, non-negotiable bedtime routine should be implemented. Make bedtime pleasant and never make going to bed a punishment. If your child gets out of bed, calmly and immediately lead them back.

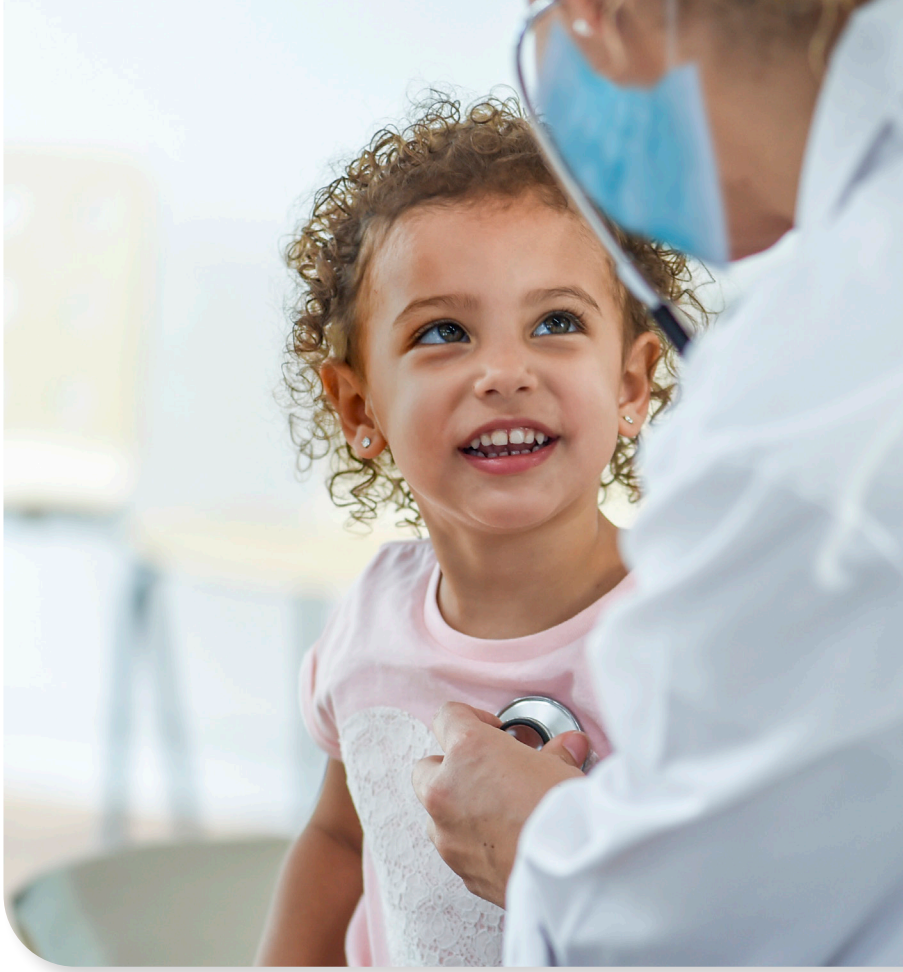
Sleepwalking or night terrors, often accompanied by dramatic symptoms such as elevated heartbeat, rapid breathing and sweating affect 25 percent of children. Children may be unresponsive to the environment and not remember the episode upon awakening. A sleeping child who suddenly awakes screaming, thrashing wildly, sweaty and with dilated pupils is likely having night terrors. Most times, after 10 minutes or so, the child will return to a calm sleep state. Episodes are worsened by inadequate or disruptive sleep. Stress reduction or a brief afternoon nap may be helpful.

What's the difference between night terrors and nightmares? A child having a nightmare may awaken spontaneously and will usually remember the dream. There is little movement during the episode and once the child is awake, he is consolable. Anxiety or disturbing daytime events may trigger nightmares. Television shows, movies, video games and books should be screened for material that may be too frightening.

In most children with a behavioral sleep problem, a detailed history and physical examination are sufficient to provide an accurate diagnosis. In cases where further study is warranted, the studies should be tailored to each child's needs. An overnight sleep study is useful if a disorder such as nocturnal seizures, obstructive sleep apnea or narcolepsy is suspected. Consultation with your pediatrician or a sleep specialist is the first step toward a restful night.

Dr. Lee Choo-Kang is a Mercy Clinic pediatric respiratory and sleep medicine specialist at Mercy Children's Hospital.

Childhood Aches and (Growing) Pains — What's "Normal"?



"I…hurt…my…KNEE!" your child screams in between sobs.

"What happened?" you calmly ask.

"I fell down and scraped it!"

"Well, let's clean it up, put a Band-aid on, and get you back outside."

This scenario is so commonplace in a household with children that most parents don't even realize they've just effectively conducted a medical office visit for a pediatric patient complaining of musculoskeletal pain, or pain that affects the muscles, joints and tendons along with bones. Fortunately, as in this case, the cause of pediatric leg or arm pain is often fairly clear and doesn't require extensive investigation. However, the cause of musculoskeletal pain isn't always so obvious and can lead to significant discomfort and anxiety for children and their parents.

"Growing pains" are one of the more troublesome causes of childhood musculoskeletal pain. This condition is surprisingly common, affecting as many as one-third of children between the ages of three and 12. Frequently, the problem has a family history. Interestingly, the term "growing pains" is a bit of a misnomer since the pain doesn't necessarily occur during growth spurts or even in areas of the body where the most active growth is occurring. Consequently, many physicians have taken to calling it "benign limb pain of childhood."

Typically, children with this condition experience intense pain in both shins, often lasting up to an hour or longer, during the evening. These events can awaken them (and the rest of the family) from sleep and cause significant amounts of distress for everyone involved. Physically, everything appears normal and there are no other signs of illness. Comforting measures, such as rubbing the painful parts, usually provides eventual relief but medications like ibuprofen or acetaminophen can also be helpful.

Children who are otherwise healthy and growing normally and who experience occasional growing pains don't usually require additional medical exams. However, red flags that should raise suspicion and might warrant further evaluation include: pain which occurs on only one side or limb, symptoms that persist during the day, associated bone or joint swelling, or symptoms of illness such as fever, weight loss or excessive fatigue.

Although our understanding of why benign limb pain of childhood develops is limited, we know that most children grow out of it and don't suffer any long-term complications. Unfortunately, some children and families do continue to deal with recurrent attacks for years. There's some solace in knowing that even in these longer cases, episodes generally become less frequent over time and no physical damage is being done.

Dr. Bradley Ornstein is a pediatric rheumatologist and infectious disease physician with Mercy Children's Hospital and Mercy Clinic.

Helping Kids Overcome Shyness

Shy is a term many of us use to describe a child who doesn't talk much or like interaction with others. The term tends to come with a negative connotation that can actually be harmful to the child.

The truth is, being shy isn't necessarily a bad thing. Often these children are simply observing a situation before reacting. It's important to be careful how you use the term "shy." Some kids hear it and think it's bad, which can ultimately make them retreat more.

As kids grow, they transition from playing alone to parallel play, and finally to interactive play. They become more open to friendships and most don't have trouble maintaining them. However, parents who have a child that is a little more reserved might find themselves asking if there is something wrong with their child or if they can help the child become more comfortable.

The best thing you can do for your reserved child is to plan ahead.

- Before entering a new situation, give your child some advance notice of where you're going, how long you'll be there, who will be there and safe areas for time away.
- If you want to have a playdate for your child, first and foremost make sure the child you're inviting is a good match for your child. If you pair an introverted child with a hyper-extrovert, chances are they won't do well together.
- Have a clear start and end time. Lengthen the time if things go well.
- Have activities in mind ahead of time and don't allow withdrawal into video games.
- After starting the first few activities, encourage the children to plan the next one. Activities don't need to be elaborate or expensive. Playing a game, having a snack or working on an interesting activity is a good start.

When a child's introverted personality extends to multiple settings or gets worse, you might need to seek the support of a therapist to help with simple strategies. If shyness is severe and not improving with therapy, a psychiatric referral may be needed.

Overcoming shyness is a process, and it will not happen with a single experience. Confidence comes with many positive experiences. Allow for a few playdates and gauge how the child is doing before setting higher goals of more playdates, longer periods or more stimulating environments.

Dr. Duru Sakhrani is a Child and Adolescent Psychiatrist.

Post-Traumatic Stress Disorder in Children

Kids are inherently sensitive to things happening around them. They are easily affected by visual images and are surprisingly perceptive of their parents' reactions, concerns and anxieties, along with those of others.

Children react to disasters (natural or man-made) differently than adults. A child's age plays into how they cope with disaster. Reactions can range from being clingy and refusing to leave a parent's side, to stomachaches, headaches or refusing to go to school or other daily activities. In some cases, sleep patterns change to include vivid dreams, nightmares and night terrors.

Acute stress disorder, which is the immediate surfacing of symptoms, isn't uncommon in children. Post-traumatic stress disorder describes the same set of symptoms but may occur a month or so later. In many cases, children may relive the disaster, becoming jumpy and startled, or they may avoid any reference to the experience. They may withdraw from friends, family or favorite activities. Changes in appetite and sleep accompanied by academic decline or attitude changes may be signs that they need to get help.

Parents can help their children deal with disaster by acknowledging the experience. Expression of feelings can be aided using drawings, through doll play, and creating stories.

In the case of disasters and traumatic events, basic necessities should be provided for children. The recognition, validation and treatment of mood changes and anxiety can come over time. Speaking with victims, witnesses and care providers is also an essential part of healing.

While memories of the traumatic event can fade or improve with time, the experience stays with the child as they grow older. It can become part of the child, impacting personality as it evolves, especially if there is a predisposition for depression and anxiety in the family.

Early recognition of symptoms and early intervention is important for kids who have experienced a traumatic event. If you are concerned about your child, call your pediatrician for recommendations and/or referrals to a counselor or therapist for individual or group therapy. This will allow your child to talk about the cause of their anxiety and learn strategies to appropriately cope with their experiences, feelings and fears. In severe cases, medication may also be an option. The main thing to remember is to be aware of your child's reactions and behavior and address them as soon as possible. It will both help your child and put your mind at ease.

Dr. Duru Sakhrani is a Child and Adolescent Psychiatrist.

Childhood Gastro-esophageal Reflux: When to Worry?

It is important to know that we all reflux! The backward movement of stomach contents into the food pipe, a.k.a. the esophagus, is termed gastro-esophageal reflux, or GER.

The frequency of GER changes from infancy to adulthood, with more than 50 percent of infants refluxing during a 24-hour period and only 10 percent of adults doing the same. The reason for this is the immaturity of the sphincter that separates the stomach from the esophagus. Even when stomach contents make their way into the esophagus, there are mechanisms in place to squeeze these contents back into the stomach rapidly. When we have overwhelming amounts of stomach contents or improper clearance mechanisms, the result is gastro-esophageal reflux disease or GERD.

So what makes "good GER" turn into "GERD"? In children, the difference is simpler and the following symptoms should raise red flags:

- Poor weight gain
- Blood or green-colored bile in vomiting
- Associated cough or choking with the reflux
- Symptoms that worsen rather than improve over time

Infants may manifest these symptoms with irritability, feeding refusal, spitting up and coughing. Older kids complain of heartburn, wet burps, tummy aches or even congestion and frequent throat clearing. These symptoms require a visit with the child's physician.

The physician may initially recommend age-appropriate reflux precautions. For infants, these include implementing smaller feeds, burping during feeds, keeping the infant upright 30-45 minutes after feeds and/or thickening the feeds. For older children: weight control, avoiding carbonated beverages, chocolate, peppermint and high acid foods, along with loose-fitting clothes and attention to timely bathroom visits to decrease abdominal distention or bloating.

If conservative measures fail to alleviate the complaints, a more thorough investigation may be undertaken. Though the history and exam are usually enough to make the diagnosis of GERD, further testing may help quantify and assess the presence of any damage.

Diagnostic tests available include pH monitoring either with a catheter down the nose or with an innovative wireless device placed in the esophagus. In select cases, special X-ray studies using a dye to illustrate the anatomy or plumbing of the upper tract may be beneficial. We also may perform an upper endoscopy exam to visualize the tissue and, if needed, take biopsies to further define the cause and extent of disease. Biopsies are especially useful in patients with an allergic predisposition such as asthma, allergies, eczema or a family history of GERD. Recent literature has shown the presence of allergic esophagitis is the cause of some of these GERD-like symptoms. Allergic esophagitis is a condition that causes the esophagus to swell in reaction to certain allergens.

In summary, for most children, pediatric gastro-esophageal reflux is a self-limiting condition. However, attention needs to be paid to children who have poor weight gain, persistent or worsening symptoms or other associated non-gastrointestinal findings.

Amana N. Nasir, MD, is a Mercy Clinic pediatric gastroenterologist with Mercy Children's Hospital.

Things to Consider When Getting a Family Pet

Kids often hope for a new furry friend around the holidays. Parents should be aware, however, that while the idea sounds wonderful, there are several important things to consider before bringing a new pet into the family.

The type of pet, the time and expense a new pet will require, as well as everyone's expectations of the new member of the family, should all be considered. Families should make a list of wants and needs for the new pet. For example, do you want a lap buddy, a running partner, a playmate for the kids? And who will be the primary caretaker?

Any pet requires daily time and attention, but some are more time-intensive than others. They can be expensive, too. The costs associated with properly caring for a pet must be considered. People often account for the initial investment but don't always think about the fees for routine veterinary care or the costs of feeding and grooming. Pet insurance is an option that can help with costs, but do most new pet owners consider it? Probably not.

Dogs tend to require the most in terms of time and attention. Puppies have lots of energy and significant time is required for adequate training. Families with young kids and/or lots of activities should evaluate how much time they actually have to devote to a new puppy. An adult dog from a reputable rescue organization might be a better option. Temperament and energy level are more determined, and it will be easier to decide if the dog will fit into your family's lifestyle. If considering a purebred dog, research breeds. Although every dog has its own personality, there are certain characteristics consistent in breeds that may or may not be desirable for your family dynamic.

Cats also make very good pets. Although less time intensive than dogs, they still require regular attention, grooming and daily maintenance. An adult cat, as opposed to a kitten, can be a good option for your family for the same reasons as an adult dog.

Another option is a pocket pet. These can include guinea pigs, ferrets, hamsters or rats, to name a few. These animals require less time and can be a good choice for the active family who would like to have a pet but may not have much extra time to devote to a dog or cat.

Finally, it's vital to consider not only your family's needs and wants, but also those of the pet. If proper preparation is taken in choosing the right pet, it can be a rewarding and fulfilling experience for both parents and kids to have a beloved pet as a member of the family.

When Should Your Daughter First Visit a Gynecologist?

It's not always a question parents want to think about, but when you have a girl it's a fact of life. At what age should your daughter start seeing a gynecologist?

The answer varies with each young woman depending on her needs, but there are many reasons for girls to begin seeing a gynecologist as soon as menstruation starts. One of the most common is a heavy and/or painful period. While this can be normal, it may also be an indicator of a more serious condition, such as endometriosis. Regardless of the cause, pelvic pain and painful periods are important symptoms to investigate. They can also affect academic performance by causing girls to miss school.

A gynecologist can often determine if there's cause for concern based on history alone. In most circumstances, invasive exams can be avoided, and there are several effective treatment options for painful periods and endometriosis.

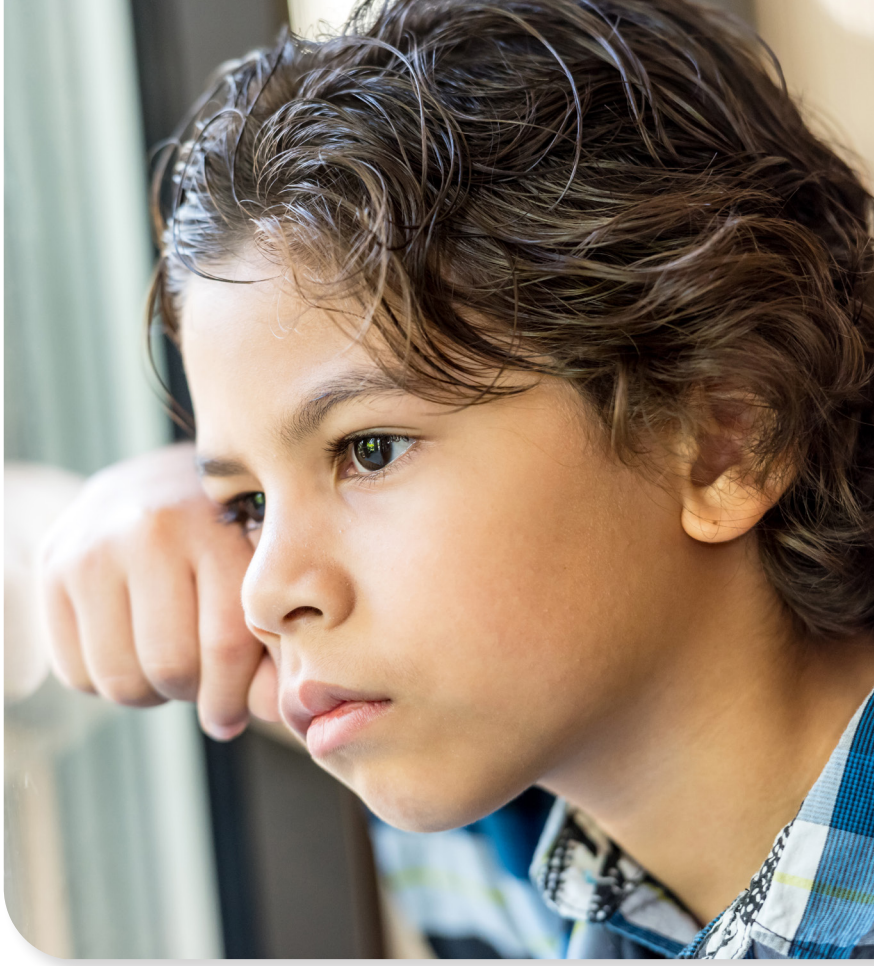
Another good reason some parents want their daughters to visit a gynecologist is for general consultation on sexual and reproductive health. Many girls benefit from a one-on-one tutorial about the changes in their bodies, the menstrual cycle and reproduction. While open communication between adolescents and their parents on these topics is optimal, sometimes these conversations can be difficult for both the parent and their teens. Having this information revisited by a health professional allows for frank discussion on these issues. It can also help foster more effective communication at home.

A third good reason for a teen's visit to a gynecologist is that adolescence is an important time to discuss immunization status. Currently, the HPV (Human Papillomavirus) vaccine is recommended between the ages of nine and 15, but can be given as late as age 26. This visit is an opportunity to discuss the vaccine, its importance and the risks of immunizing versus not immunizing.

Even without health issues, it's important for a young woman to establish a trusting relationship with a gynecologist by age 18. While pap smears and routine pelvic exams are no longer recommended before age 21, a young woman should have a gynecologist she knows and trusts prior to any issues or needs that may come up.

Dr. Gretchen Levey is a Mercy Clinic OB/GYN.

Depression in Children



Your child is sleeping more than usual. Your teen is withdrawn and doesn't spend as much time with family as before. While these signs can seem like typical teenager behavior, they also can mean depression. Depression is not restricted to adults and is very common among children and teenagers.

According to the American Academy of Child and Adolescent Psychiatry, depression is defined as an illness when the feelings of depression persist and interfere with a child or adolescent's ability to function. Most of the time, fleeting blues get better after a few days. It is when changes in mood and behavior persist that depression becomes a concern.

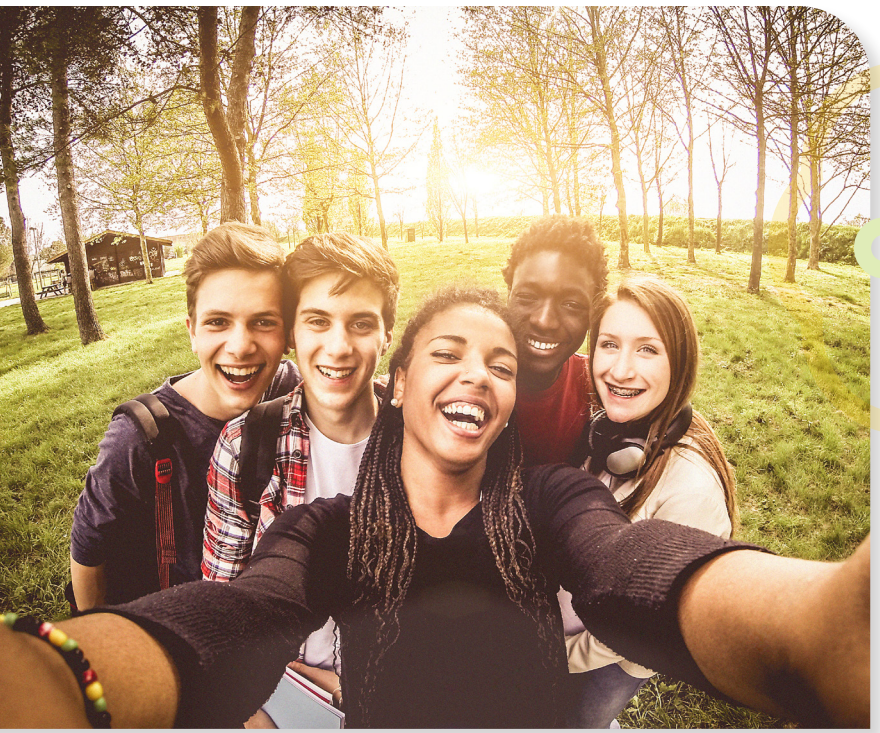
The statistics on depression are staggering. According to the U.S. Center for Mental Health Services:

- As many as one in seven children and one in eight adolescents may have depression.
- Once a young person has experienced a major depression, he or she is at risk of developing another depression within the next five years.
- Two in three children with mental health problems do not get the help they need.

The risk of depression in children is higher when there is family history. But even if you know an adult who suffers from depression, be aware because the behavior in depressed children and teens differs from that of depressed adults. If you notice your child exhibits one or more of these symptoms, you should talk with a doctor:

- Sad, tearful and overly sensitive with very little or no provocation
- Withdrawn from friends and spend more time alone
- Changed behavior patterns and loses interest in activities that were previously interesting
- Eating and sleeping patterns may change
- Grades and academic performance are affected
- Poor self-esteem or guilt
- Frequent physical complaints, such as headaches and stomachaches
- Lack of enthusiasm, low energy or low motivation
- Drug and/or alcohol abuse

While depression sometimes improves spontaneously, it also can get so severe that thoughts and talk of suicide emerge and cannot be taken lightly. Early diagnosis and intervention is important for youth with depression. If you are concerned about your child, call the pediatrician, who will make recommendations such as referrals to a counselor or therapist for individual therapy. This will allow children to talk about their stressors and learn strategies to appropriately cope with their emotions, feelings and behavior. It is only in extreme situations that medications may be needed.



Got Acne?

About eight in 10 teens have acne, and it usually appears between the ages of 12 and 17. No teen is the same; some might be lucky and only get a few pimples. Others might get more than a few, and still others get big bumps that hurt and cover their faces.

Acne appears when hair follicles, or pores on the skin, clog up. Pores contain sebaceous glands (oil glands) that make sebum (oil) to moisten the skin. Sometimes when pores have too much oil, dead skin cells or bacteria, it can lead to acne including white heads, black heads, red bumps (pimples), bumps filled with pus (pustules) and inflamed large nodules (cysts). As teens grow up, their hormones change and stimulate oil glands to be overactive – and too much oil clogs the pores, leading to acne.

If a parent had acne as a teen, it's likely their child will have it. Luckily, for most adolescents, acne gets better after the teenage years.

Here are some simple ways your child can keep acne at bay:

- Wash the face twice a day with warm water and a mild soap or cleanser to prevent oil buildup, which can lead to clogged pores.
- Don't scrub when washing the face. Scrubbing can irritate the skin, causing more acne.
- If your child wears makeup, moisturizer or sunscreen, make sure the products are "oil-free," "non-comedogenic" or "non-acnegenic", and take time to remove all these products from the face before bed each night.
- If your child has long hair, he or she should wash it regularly and keep it away from the face.
- Wash the face after exercise.
- Don't pick or squeeze pimples.

If these tips don't prevent acne and pimples appear anyway, try over-the-counter products available at retail stores. Products with benzoyl peroxide or salicylic acid usually work well. If that still doesn't help, your child may need to see a dermatologist for acne.

Acne treatment usually includes topical antibiotics, topical retinoids or oral antibiotics. For severe and scarring acne, isotretinoin is very effective. Because there are many effective treatment options available, there's no reason your child should live with acne that's severe and embarrassing.

Dr. Wei Wei Huang is a Mercy Clinic dermatologist on staff with Mercy Children's Hospital and Mercy Hospital St. Louis.

Notes

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