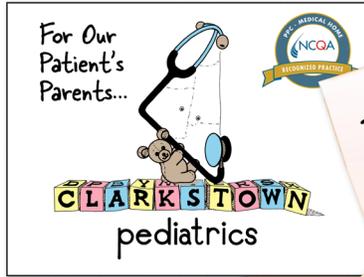


Summer 2023



PARENT LETTER

the best parents ever!



Nice to see your smiling faces again!!!

What? The PANDEMIC is OVER for real?

by Erica Berg, MD



So it's been a long three or so years and the end of the Pandemic Emergency is wonderful news. *COVID-19* virus will continue to mutate and infections with it will continue. Waves of *COVID* will still occur (mostly in winter we expect) but hopefully with global immunity at higher levels, these will be much smaller and less severe waves.

The Journal of Pediatrics this month had two interesting articles: One looked at the effectiveness of *COVID* vaccines in children and adolescents over a period that included the *OMICRON* wave. The second article addresses *COVID* vaccine safety during the first year of use in children and adolescents.

So, when looking at the *COVID* vaccine that kids and teens got (monovalent, two doses), the study showed it protected them against **mild to moderate and severe COVID-19!** Vaccine effectiveness was lower during Omicron predominance (as this was not the bivalent with Omicron protection, effectiveness waned after dose 2 but increased after a booster.

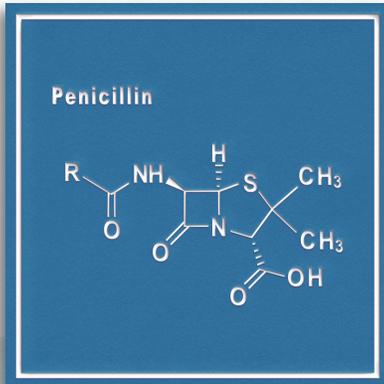
Amazingly, 83% of children and teens hospitalized for *COVID-19* were **unvaccinated**. Bottom line: **the COVID Vaccine protects** against serious disease, and all children and adolescents should receive all recommended *COVID-19* vaccinations, especially a **BIVALENT booster** if they have not already. We anticipate more waves in the fall/winter so as you schedule your fall flu vaccines, consider the *COVID* booster with us as well.

And from the second article we can feel good about the **safety** of the vaccine: During the first year *COVID* vaccine was given to teens, most reported side effects were mild and appeared self-limited. They looked at 1.2 million v-safe reports. Rates of myocarditis were lower than earlier reports (only 17 cases per 1 MILLION second doses!) and *MIS-C* (1.2 cases per million vaccine doses administered). **No new serious safety concerns** were identified. And all patients who did have myocarditis had mild illness which resolved without treatment by the time of the study.

Ok Clarkstown Pediatrics patients: let's keep our immunity up so as a community we can continue to feel safe if another wave and variant comes our way!

My child got a rash on amoxicillin, so are they **PENICILLIN ALLERGIC?**

by Doug Puder, MD



A family history of penicillin allergy is not a reason to avoid it.

If your child does get a rash while taking an antibiotic, stop giving it right away and call us. Benadryl by mouth should be given. Take a photo of the rash if you can. The rash could be caused by penicillin allergy, but **true penicillin allergy is rare in children.**

Penicillin allergy is reported in about 10% of children, yet a full **95% of these children are not allergic!** Most rashes which occur while on penicillin class antibiotics are from viruses, eczema, etc. Amoxicillin and amoxicillin-clavulanate are the most common penicillins medications we use.

Sometimes your doctor can rule out allergy by taking a careful history and examining the rash. Viruses such as *roseola* (sixth disease) give high fever followed by a classic rash which doesn't itch or hurt. If your child was taking amoxicillin at that time (maybe for an ear infection), the rash may be **mislabeled** as a penicillin allergy rash.

Yes, true penicillin allergy can lead to *anaphylaxis*, a life-threatening condition with dizziness, difficulty breathing, swelling of the tongue or throat, very low blood pressure, and vomiting. So if our evaluation cannot rule out penicillin allergy, before giving amoxicillin again, we recommend testing by an allergist.

There is a penicillin skin test which is used if history and examination of the rash do not rule out allergy. It is followed by an oral challenge if the penicillin skin test is negative. Typically about 10% of a treatment dose of amoxicillin is given and your child is observed in the office for 20-30 minutes. Then the remaining 90% of a treatment dose is given with another one to two hours of observation. If there is no reaction to this, your child's medical record should be delabeled and "penicillin allergy" removed.

A family history of penicillin allergy is not a reason to avoid it. Drug allergies are not passed on from parent to child. A mom, dad, brother or sister with an antibiotic allergy is not a reason to avoid the medication in another family member.

If your child is tested and is found to be penicillin allergic, we will carefully label your child's medical record. This information will be transmitted to your pharmacy as well. Many studies have confirmed that the cephalosporin class of antibiotics can be safely used in penicillin allergic children. First generation cephalosporins (cephalexin) have less than a 5% risk of allergy. Second, third, and fourth generation cephalosporins have no cross reaction risk with penicillin allergy.

Why bother testing? Children with penicillin allergy may require more expensive, sometimes overly broad spectrum, and sometimes less effective treatments. Risks of antibiotic resistance increases. So we think it is worth testing!

We hope you find our Parentletter helpful and informative. Please keep in mind that receipt of this newsletter does not create a doctor/patient relationship and that it is not meant to serve as a substitute for professional medical advice. For particular pediatric medical concerns, including decisions about diagnoses, medications and other treatments, or if you have any questions after reading this newsletter, we encourage you to speak with your child's pediatrician.

Can we give antibiotics for fewer days?

by Jaimie Samuel, DO

Antibiotics are an important tool pediatricians use to treat common infections. They are not effective against viral infections but they may be needed to treat ear infections (*acute otitis media*), urinary tract infections (*UTI*), pneumonia, skin infections, etc.

For decades 10 day courses of antibiotics were prescribed for these infections. To help slow antibiotic resistance and decrease side effects, recent research has studied shorter courses of antibiotics. It also makes things easier for parents and may cost less. Sometimes shorter is just as effective and sometimes it is actually better. Don't be surprised if we discuss these changes with you!

Ear Infections (Acute Otitis Media):

Acute otitis media is the most common condition in children which may need antibiotics. But many ear infections can be viral and improve on their own without antibiotics. So a "watchful waiting" approach is best for infants 6 months of age and older with a mild-moderate unilateral (just one ear) infection.

If antibiotics are needed, the AAP recommends length of treatment based on severity and the child's age. For severe symptoms or for patients under 2 years of age, the standard 10 day course of antibiotics is still recommended. For children 2-5 years of age with non-severe infections, a 7 day course is enough. Ages 6 and older with non-severe infections, a 5 day course of antibiotics is recommended.

Urinary Tract Infection (UTI):

For an uncomplicated UTI (without fever,) a course of 3-5 days of antibiotics works well. For a more complicated UTI (fever or symptoms of kidney infection), a longer course of 10 days is recommended.

Community Acquired Pneumonia (CAP)

Studies have shown children who received a 5 day "short course" of antibiotics did as well as those getting 10 days. There were less side effects from the antibiotics with 5 day courses.

Skin and Soft Tissue Infection:

Impetigo (strep and/or staph bacteria in the skin) and abscesses need antibiotic treatment. Uncomplicated skin infections usually need only 5-7 days. For minor infections, treatment can be as short as 3 days if clinically resolved. The length of antibiotic treatment is based on how quickly your child responds.

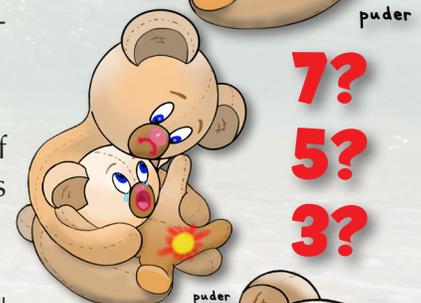
Streptococcal Pharyngitis:

NO changes to the standard 10 day course of antibiotics! It takes 10 days to protect your child's heart from rheumatic fever.

These are only guidelines, your doctor will discuss the best course of treatment for your child with you. The doctors at Clarkstown Pediatrics have discussed these changes and thought you should be aware. **We want to use antibiotics carefully so they will work when your child really needs them!**



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Our Eckerson Office will close this Fall:

by Gregg Rockower, MD



open 365 Days!

About 35 years ago, Clarkstown Pediatrics outgrew our old home at 259 North Middletown Road and added a satellite office at 200 East Eckerson Road in New City. As time marched on, some new doctors joined the group and some of the senior partners retired. Clarkstown Pediatrics modernized our facilities in order to provide the most current level of care to our patients and their families. Many of these enhancements are behind the scenes such as our laboratory and vaccine storage, while other enhancements are more evident like our electronic records, telemedicine, and of course our new office at **25 Smith Street**. We are proud of our NCQA (*The National Committee for Quality Assurance*) level 3 rating (the highest) which recognizes these enhancements.

Continuing our effort to evolve for the better, it is with mixed emotions that we are **announcing the closure of our site at 200 East Eckerson Road in October of 2023**. For those not familiar with the new 25 Smith Street office, it is a short 5-10 minute drive from the Eckerson location. Drs Rockower and Berg will be available with the same access as always.

Patients might have to get used to the beautiful and large waiting rooms and oversized and bright exam rooms, but I'm confident that we will all adjust. The new office is "state-of-the-art".

Our 25 Smith Street office is open **7 days a week** and has evening urgent care hours Monday through Friday starting at 6pm. It will be open on all holidays as well.

While this move is sad after so many years practicing at 200 East Eckerson, the consolidation brings us all home. Clarkstown Pediatrics will remain your medical home for your children.

What is a Swimmer's Ear?

by Doug Puder, MD



An ear infection forms when bacteria and viruses grow in the middle ear (behind the eardrum). But with **swimmer's ear**, the middle ear is fine while the skin lining the ear canal is infected.

Children with **swimmer's ear** have ear pain (especially on movement of the outer ear), and sometimes discharge from the ear.

If needed, middle ear infections will be treated with oral antibiotics. **Swimmer's ear** is treated with antibiotic eardrops. Avoid underwater swimming for a few days until the infection heals.

Water in the ear has no effect on a middle ear infection, but water bacteria cause **swimmer's ear**. Ear plugs are helpful to prevent **swimmer's ear** only if a proper seal is formed. We do not recommend earplugs for most children swimming in pools, and they may have trouble hearing the lifeguard! We prefer 2% acetic acid drops (*OTC swimmer's eardrops*) before and after swimming for prevention of **swimmer's ear**. We also remind parents that *Q-tips* should not be used in the ear. Children with too much earwax may benefit from having the wax removed as it may trap water bacteria in the ear canal.

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