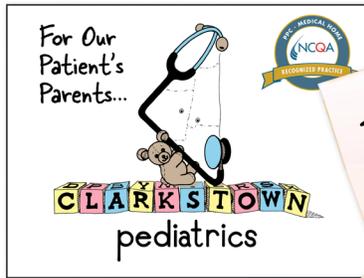


Spring 2021



PARENT LETTER

the best parents ever!



Time to Get Students Back into Classrooms!

by Doug Puder, MD
and Erica Berg, MD



Schools Are Essential Services!



In school learning is best for students. In person education (K through 12th grade) has been shown to be safe when the right protocols are used. This is the opinion of our doctors at Clarkstown Pediatrics along with **six thousand New York State Pediatricians!**

School closure was mandated during the lockdown and peak months of our COVID pandemic. We understood the need to minimize COVID spread and keep children safe. But we also see how school closure hurts the education of our children. Some students may have *permanent* effects on their learning, social skills, and emotional health.

Our Chapter of the American Academy of Pediatrics says: "Elementary age students are facing staggering losses in expected literacy and school success." "Schools should be treated as essential services." Schools should be among the first to reopen when the COVID rate in our community drops. As long as we keep up mask wearing, handwashing, putting students into pods (cohorting), and social distancing schools can remain safe.

How did we come to this conclusion?

- The positive COVID rate in our schools is no higher than the rate in our community. Very often schools have lower positivity rates!
- Although cases have been brought into schools by staff and students, there is very low transmission between students or students to staff. The highest risk was staff to staff which should hopefully be minimized with more vaccinations.
- When a case of COVID is detected in a class, good protocols can contain it with little spread. (When COVID has spread in schools it is almost always because safety protocols were not followed.)
- Our schools practice mandatory in-school facemask wearing, social distancing, and cohorting students into pods. Most other countries don't require these protocols. So our schools could be the safest in the world!
- The risk of COVID infection must be taken very seriously. But we have learned how much children suffer with all remote learning! The impact is greatest for our special needs students (ELL, SPED) and Pre-K through 2nd grade students. They have already missed out on a year of in-person learning. Let's get them back!

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Molluscum

Editor's note: I asked Dr. Berg to write something about this common skin condition just before the pandemic hit. So it's been sitting on the shelf since while COVID took center stage. It feels nice to be able to talk about some non-COVID stuff again!

by Erica Berg, MD



Molluscum contagiosum is a common skin infection in children that is caused by a poxvirus. (*Varicella*, or what we often call *chickenpox*, is not in this class of viruses.) It produces harmless, non-cancerous growths (*mollusca*) in the skin's top layers. The disease is spread by direct contact with the skin of an infected person, or by sharing their towels, etc. So if a child scratches one of their own *molluscum* growths, then accidentally scratches another child, the virus transfers. Molluscum is most common between the ages of one and ten years. It is quite unusual over age ten.

Molluscum contagiosum causes dome-shaped bumps (nodules) on the skin. They tend to be very small, shiny, and flesh to pinkish color. They are raised with an indentation or dimple in their center. They are found most often on the face, trunk, arms, or legs. But *molluscum* may grow anywhere on the body except the palms of the hands and soles of the feet. They are painless and may last for several months to a few years. The most common length of time is 18 months! Most kids get between 2 and 20 of these growths.

Warts are also skin virus growths, but wart medications will **not** work for *molluscum*. Molluscum nodules go away on their own without treatment most of the time. This means that most children with just a few scattered growths do not need any special care. If it is driving you and your child crazy, and it's been "forever", a dermatologist can remove them. Options are a scraping procedure with a sharp instrument (*urette*), using peeling agents (such as *cantharidin*), or freezing techniques (*liquid nitrogen*). These methods may be painful and can cause scarring on rare occasions. If you let molluscum go away on its own, there will be no scarring. ***Pediatricians and Dermatologists agree that no treatment is best most of the time!***

It is not a good idea to try and remove lesions or the fluid inside of lesions yourself. You may unintentionally spread it to other parts of the body or risk spreading it to others. Scratching or scraping the skin could cause a bacterial infection on top of the molluscum.

Bottom line? There's not much you need to do about it. Try to keep your child from scratching the area because that can cause new ones to crop up. Then the waiting game for it to go away starts over. If a *molluscum* growth looks more red and swollen, call us or schedule a *TeleVisit*.

If you have any concerns about your child's *molluscum* at any time, of course we are here to examine it. We can tell you if it's looking a little worse as it is healing, or if it has become infected.

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Springtime Allergies or COVID?

❑ Is my child's runny nose from allergies? COVID test? by Doug Puder, MD

Sneezing, runny nose, red itchy eyes, and throat are typical symptoms. A springtime "cold without fever that just won't go away" is still most likely allergy. We'll discuss if your child needs a COVID test to be careful. Spring allergies usually happen to more than just one family member. Infants and toddlers can have food allergies, but springtime allergy is uncommon before age 3. Runny noses of infants and toddlers are usually from viruses because it takes several seasons of pollen exposure before spring allergy develops. Luckily, most allergies today can be controlled, and suffering greatly reduced. Tree pollen is highest in April/May. Grass pollen peaks in June.

❑ What are the Steps to treat springtime allergy?

Step 1

Start with a Non-Drowsy Antihistamine

These are all OTC now! Available as pills-liquids-meltaways-chewables:



- Loratadine (*Claritin/Alavert*)
- Fexofenadine (*Allegra*)
- Cetirizine (*Zyrtec*)
- Levocetirizine (*Xyzal*) (*less sedating than cetirizine*)
- Diphenhydramine (*Benadryl*) (*very sedating-use at bedtime*)



If that doesn't give enough relief, add a **cortisone** nasal spray to reduce nasal inflammation. Nasal cortisone sprays all work equally well. Many are OTC now:

Step 2

Add a Nasal Cortisone Spray



Use 1-2 sprays each nostril for the first week, then decrease to one spray daily. Continue until pollen levels drop:

- OTC: ● **Flonase** ● **Nasocort** ● **Rhinocort**
 Rx: ● **Fluticasone** (generic Flonase)

Step 3

Add Allergy Eyedrops



If the eyes are still itchy, use one drop in each eye. Most are OTC:

- **Pataday** (once daily) ● **Pazeo** (high strength Pataday)
- **Zaditor** (3x daily)
- **Olopatadine** (generic pataday/pazeo) ● **Ketotifen**

Step 4

Time to see an Allergist?

● **Montelukast** (*Singulair*), ● **Azelastine** (*Astelin*) and others may add a little more relief. But if your child or teen is still miserable after steps 1,2,3 we recommend testing by an allergist. *Immunotherapy* (allergy shots) or daily drops under the tongue can make a huge difference. The benefits should be long lasting.

It also helps to track pollen levels with one of many free apps. It helps to change clothes (and masks) when coming indoors. If you have contact lenses, switch to glasses until pollen levels drop. Think about running an air conditioner or HEPA filter. Make an appointment and we'll guide you!



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When Is It Safe to Go Back to Sports After COVID?

by Doug Puder, MD



COVID-19 infection can sometimes cause *myocarditis* (inflammation of the heart). How often does this happen? Not often. But since *myocarditis* is a known cause of sudden cardiac death in athletes we need to carefully evaluate post-COVID. What is needed before your child or teenage athlete can participate safely?

All student athletes should be evaluated by one of our doctors before returning to sports. Heart (cardiac) testing may be also needed. It will depend on which level of COVID infection your child had:

● Asymptomatic infection

They had COVID but never felt sick. If there are no symptoms or findings which concern us when we examine your child and at least 10 days have passed since COVID was diagnosed, they can return to sports. An EKG or cardiology evaluation is **not** needed.

● Mild infection

They had fever for 4 days or less and aches/fatigue/chills for less than one week. If there are no symptoms or findings which concern us when we examine your child and at least 10 days have passed since COVID was diagnosed, they can return to sports. An EKG or cardiology evaluation is **not** needed.

● Moderate Infection

- ◆ They had fever for more than 4 days, *or...*
- ◆ Aches/fatigue/chills for more than 7 days, *or...*
- ◆ Hospitalized for COVID but didn't need ICU care.

A full examination in our office and an EKG are needed.

If the exam and EKG are normal, they can return to sports.

● Moderate to Severe Infection

If during their COVID infection they had chest pain, significant shortness of breath, very rapid heart beat, fainting or abnormal EKG they should have a full evaluation with a pediatric cardiologist before returning to sports.

● Severe Infection

If they were treated in an ICU or diagnosed with *MIS-C* (*Multi-Inflammatory Syndrome in Children*). They should have a full evaluation with a pediatric cardiologist before returning to sports.

After recovering from COVID-19 infection, we recommend restarting exercise gradually. The intensity of exercise should start light and work up to pre-COVID intensity over one week. Parents/coaches should watch recovering athletes for chest pain, shortness of breath, unusually fast heart beat, or lightheaded dizzy feelings (near fainting).

Thankfully, to date all of our patients who have had COVID have recovered. We are glad to see them enjoying full sports activity again!

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