Opening Banter and Guest Introduction

So we actually take a call from home, which is really cool and almost unheard of in the pediatrics world. We also are kind of a growing community hospital.

So the ER isn't always staffed with pediatricians, so we do get called in. I mean, people like me are staffing your EPDR. And you guys do great. But it's like always at 3am that you're like, I'm not sure.

That's the witching hour. It's funny because so it I guarantee you that patient came in at like 1am, the doc probably saw they're, like alright, it is, you know, whatever I can do this and then two hours later they are like Shit right.

I don't know. Can you just like be sure they're okay? Yeah, you know look at this child. Yeah Hey everyone and welcome to the next episode of the Jaffercast.

I am your host Dr. Mark Papadakis. No one particularly special, just another fucking ER doctor. So today we're going to be having Dr Maggie Gorin here.

She's a world famous pediatrician. I went to medical school with her. She was one of my former classmates the year behind me. And I'm lucky to have her here with me to discuss, we're going to be testing pediatric fevers and largely other pediatric based things, but mostly pediatric fever.

That's been a topic in my ER discussion for some time now, especially with the recent cold and flu season ending. For us, at least it was pretty bad. So let's get her in here.

I'm here at Dr. Maggie Gorin. Hi. So, Maggie, tell us a little bit about yourself. Obviously, I told people already, you and I went to medical school together, but just kind of talk about that.

Residency, training, etc. Please. Very sure. Yes. So we were Toro Harlem. You're a year ahead of me. I graduated in 2017. 2017, yeah. It's been a long, long few years.

Really, it feels like so much longer. And I went into residency in pediatrics. Did my residency out at Good Samaritan Hospital out in Long Island, New York.

Maggie Gorinu2019s Training and Career Path

Oh, I didn't know that. Yeah. Cause we were at NIAC together. We were, we did our third year rotations each at NIAAC. Um, and that was, I had a lot of fun.

I know you did as well. So you were in, so, uh, Long Island and then, um, you, what about post residency? Um did you know, did, do you want to do anything particularly special?

Did you to specialize in anything or were you just like, i've always wanted to just be a pediatrician. So I knew a hundred percent that I did not want to deal with adults.

I don't blame you. Adults are cursed back and they're not as cute. Yeah, so I actually I was an EMT for six years before I went to med school and so, I Did the the adult thing mostly then and I like no, that's not for me.

And you got your taste of emergency medicine during that as well. So, yeah I thought of it. Fellowship so in pediatrics all fellowships are three years, which is frustrating.

Okay, so our our residency is three and then a fellowship is 3 years a lot of times in adult medicine. You know, as

you know it's one year or 2 years but.

For some reason, in pediatrics, we don't have that. We do have pediatric, and I know you can do either one. So if you decide to do emergency medicine, you would do an emergency medicines fellowship for three years?

How does that work? So I'd have six total. Okay. That's funny because most standard residency programs in emergency medical are three-years. Or maybe four, depending on the place.

Yeah. So it always ends up being, being a little longer than, than some other fields. I had thought about doing, you know, Penn fellowship, but I, I. Signed up for the national health service core while we were at Toro.

If people don't know what that is, they offer you here's. some money to put towards your loans, which I still have a lot of. I had done my master's in public health, I was a little bit older when I went back to school, so I knew I needed help with the loan.

So I did National Health Service Corps, basically I owed them three years of service in an area of their choosing. And so they try to find underserved areas, which, you know, luckily, unluckily, New York City counts.

All of New york city or just parts of the city? Yeah, parts. So I ended up in Hunts Point in the Bronx at a clinic, at the government clinic. You know, federally qualified health center there and, you know did my time there, but it's a very strict program.

So right. Like you, take a day off or you have like scheduled closure days for clinic and they like tack that on at the end of your thing. Right. We have a snow day and then all of a sudden you owe like an extra day.

So, and I took maternity leave. So basically my three years turned into four years. And by the time that finished, I was like, am not going back into fellowship.

Yeah, a hundred percent. That's something that people don't really understand either. So you did four years of undergrad. How long was your master's? So I did 4 years in undergrad and then I was a master of public health at Mount Sinai and I worked.

And then medical school after that? No, I took time. I guess it was like 5 years total difference from when I graduated undergrad Okay. So then medical school happens, four years of medical and now the pediatric residency happens.

And this is something a lot of people don't understand as far as our training goes too. It's not just medical, it's also undergrad and whatever other thing that we decide to do, plus medical plus residency.

And now all of a sudden, you're 38 years old. I don't have a child or I'm not married right now. That's exactly. Yes. Did you read the story of my life?

That is, that is what happened. So, by the time that finished, I was like, all right, i'm, not going back. Plus, COVID broke all, of us a little bit. It was because you graduated residency.

You finished residency- 2020. In 2020, so you were right. So we and Sam had one of the biggest, one the hardest hit areas for COVID. Mike, our PICU turned into adult COVID ICU.

I was a third year pediatric resident caring for all COVID, ICU, you know, vents and coding and things that I hadn't done since. Trial by fire, for sure.

Yeah. So after that I said, I need to just live. Be in a clinic with kids somewhere and not in the ICU.

Working as a Community Pediatric Hospitalist

That's understandable. I did that for a couple of years and then I, said I needed to not do that again. To get back in hospital. It's always gotta be something.

Yeah, so now I'm back working as a hospitalist, which interestingly as in pediatrics, that is now also a fellowship. Yeah when did that happen in the last couple years they now have like hospital fellowships which is another fellowship out after you.

Do hospitals require the fellowship in order to hire you? Because it's still so new? It depends. Yeah, so it depends, I'm not fellowship trained as a hospitalist.

I worked hospitalists per diem the last four years that I was also in the clinic, and then I transitioned to full-time hospital after that. Some places now are starting to require it, some places grandfather people in.

I would imagine the places that would require it are more your specialized pediatric hospitals, as opposed to your general community hospital, a pediatric floor or something.

Exactly. And that's kind of where I am. You know, I'm in a big system, but a smaller, more community style with a, uh, pediatric. We do not have an ICU.

Okay. So anything that needs pediatric ICU level care is going to get transferred out. Yeah, they do that. No, we're working on. growing our pediatric ER.

But it's really, you know, we have a general ER and most of the week we're staffed with PEM doctors. Okay. Yeah, I'm saying the non 24 seven, you're getting guys like me in there, waking up at three o'clock in the morning to say, Hey, can you just take a look at this kid?

Can I send them home? Yeah. That's exactly what that is. You know, and it's I get it. And kids, the main thing of pediatrics that everybody says is like, kids are not just small adults, they're not, right?

So there are things about them that are gonna be different. They scare people, especially when you start having your own children and you started thinking like You know, it's funny though, when I had my first child, I realized how much more comfortable I became around pediatric patients.

Pediatrics was not a major focus of my residency. We had a pediatric ER. It was more of an urgent care styled ER than it was a true high acute, high volume critical care type of ER So we saw all the common stuff.

We saw a lot of the colds and the allergies and things like of that nature, but we never really received training on things specifically related to like small little babies.

Small little baby, tiny, we'll call them peanuts. So I have my own peanut and there's little things that they do that you're just like, is this normal?

Yeah, should they be doing this? They're breathing a little bit weird seems wrong and so but parents would come in because we have a pediatric er We staff it overnight and the parents had come bring them in all different demographics They bring their three week old their two month old and they say hey, they did this.

Is this okay? And i'm like sure For me, it's like well, the breathing right now. They''re feeding. Okay, They don't look dehydrated and now they're sleeping.

I'm sure it''s fine Meanwhile, i''m thinking to myself I don't know. First of all, what are you describing right now? What is this? Yeah, so that's a tough thing about kids is a lot of the stuff we do in pediatrics is like, let's just wait and see what happens.

Let's wait to see if things get worse. See if they do it again. As a parent, that is terrifying, right? It is. What do you mean? We're just going to wait And not for nothing, we also as physicians understand, especially in kids, kids.

We have a mantra in emergency medicine. Kids are fine until they're not, which means they look good. They look, good they serve. And then all of a sudden they just, they tank.

Adults, it's more of, a gradual decline. Like, yeah, They're, not looking too good and you try to kind of catch them as they are, you know, circling the drain as we cross, right?

But then kids will be like they'll persist, all the sudden. And you're like, what did I just do? The parents who have kids, obviously they don't know that, but they're also, it's their child too.

They're worried. Yeah. And they are coming to you for advice. At the same time, you are like well, It's also the emergency department. I'm trained in emergencies, life-threatening emergencies.

What you were describing doesn't really sound like one, But it is also difficult to figure out what are you describing too? So the parents sometimes bring video, which helps.

How Pediatricians Judge Sick vs Well Kids

But at the time it also such a quick little snippet that you like yeah, I can see why you concerned. Right. But I don't think it's a concern right now.

And that's the disconnect that the parents sometimes don' Definitely. And, you know, I think I had mentioned this before that we go off vibes a lot in, in feeds where it's just kind of like, i don't know what that is, but it not feeling bad, bad.

So we're just going to watch it. You know? Cause like we don' like to do unnecessary things to kids. We don''t like poke them and hurt them, and do things that, we dont have to.

and so a, lot of times we''re waiting just to see if something changes and then we have do the thing. So one of our bread and butter complaints, especially this past season, was vomiting.

Parents brought their children in that, oh, they vomited two hours ago, or oh they've been vomiting for the past 12 hours. And in adults, my instinct would be, you've be vomiting 12 for hours, all right, let's get an IV line, Let's give you some fluids, check some blood work, give me some medication, and we'll get you feel a little bit better.

In kids, for me, it's, alright, depending on their age, I'll say, here's some Zofran, some anti-nausea medication. And I'll step back and I say, okay, let's give it a 30 minutes to an hour.

Try feeding them again. Or we'll do a viral swab in the meantime. And then parents are like, that's it? Yeah, what do you want me to do? Do you walk me the poke your child?

You want to take this little needle and stick it into their vein? I can. Yeah. There's all these tests and we can do all this torture and it could tell us, OK, your kid has a virus and you're still not going to anything.

It can tell us what we already know. Right. And that's, I think, the key thing there that parents, we see so many kids and like you said, you run off of vibes, but you ran off a vibes because your training is such that you see these cases ad nauseam, You develop a pattern of recognition.

So you develop these vibes that says your child looks well. I'm not worried. It's likely this. Are we going to have the exact viral definition of what you have?

Probably not. That's that's why I never mind those 3 a.m. Calls about can you come take a look at this kid because chances are I'll be able to walk in and be like yes Or no, you know, and if I don't then I'm like, okay.

Well, let's try this and it's only because that in pediatrics That what we're doing, right? Like we you're seeing it enough times and like you said before the the way a sick kid looks is bad bad There's obviously objective markers

for how sick a child is, how they look.

Can you talk about that? When you walk into a room, what do you look at? What signs do look that tells you, yeah, this child's sick. This child needs blood work, a lumbar puncture, scan, whatever.

Yeah, so, you know, obviously the other thing with pediatrics is that you're going from birth 21. So I'm going to be looking for something very different on that.

In general, if I come in and I see a four week old and they're sleeping, I am not stressed, right? They can sleep in an ER that's very loud. Because they're four weeks old, right?

So like, that's not stressing me out. If I see a toddler who, you know, just got labs drawn and an IV and I walk in and like they are not moving and they were just laying there like I call it, like a wet noodle.

That, I'm automatically like, why are you like that? You know, Why aren't you fighting? Why are not you mad? Move. Do something, please. Be mad. Yell at me, right?

If a toddler is letting me check their ears and their mouth, like their throat, no problem. I am more concerned, if I try to check the ear and they are hulking me.

Okay, this is good. They turn into Mike Tyson, still called Steve Austin, just elbowing you in the face. Exactly. You know, and no matter what, if a parent brings a kid in and they're going to say they've eaten nothing all day.

Right. And I'm going walk in the room and there are halfway through a bag of Takis. But they ate nothing. It's always going be. kind of biased what the parent thinks, right?

Because they say, okay, well, they normally eat five bags of Takis and today they ate one, you know, so that's nothing. But those are kind the things that I'm looking for.

Are they appropriately afraid of me? If that is age appropriate, are they fighting me back? You know the, do they wake up when I examine them? One of the words that, I am sure, the pediatricians in your life have said that we really hate, that parents use is lethargic.

Lethargic. Yeah. Gary Shaw's lethargic. I've learned that. Oh, he seems so lethagic, like, no, you did not just use that word. And in my training, if you're telling me that someone is lethaargic, then where's the code card?

What am I doing? Right? We're about to go down. Versus, somebody says they're leththargetic, but they are fighting me when I'm looking in their ears, different thing, right?

Some kids are sleepy, or as we're going to get into, some kids with fevers are just like mushing and blah. Right. But if They perk up, they get annoyed, and they cry.

Exactly. They throw some water on them, wake up and say, great, we're okay. We don't need to do anything. I had a case not too long ago and the patient was sick for a couple of days and it was nausea, vomiting, no real diarrhea, but they were basically not eating anything or drinking anything all day long.

And one word that I like to tell parents and even my residents is they look punky. Yes, do they use that outside of pediatrics? It's not. I don't think so.

And because parents look at me like, wait, what'd you just say, punkily? Is my kid a punk? Like, no, they don' look well. They don t look healthy. But they d n't look toxic.

Th e don''t look ill. The look like they're just blah. I don't feel good. And those are my like, blah, you know, I do this. Exactly. But yeah, lethargic is what I like.

Somnolent a little bit. So because EMS comes in with patients who are intoxicated, inebriated, they're like other lethagic, like okay, okay. I guess it'd be letha, but it's more like there's some I can go to them and say, Hey, he in there.

Hello. Yeah. Okay. Yeah, so but they're more somnolent as opposed to lethargic. We're thinking they are like… Right. Yes. That's gonna be good. Face capture too at some point.

You mentioned before, so pediatric fevers. Fevers in general, we talk about are obviously for adults, you get a 102 fever, and you're on your ass. I don't care who you are, your on you ass 102. One of the common complaints we get coming to the ER, especially in the evening hours, overnight hours.

My child had a fever. an hour ago. I woke them up from their nap and they were really warm. Check their temperature or they felt hot, whatever. They have a fever.

Please help me. And they kind of, you know, they give you the child. Take this, yes. Just take them. So when, first of all, the question is, when is a fee for a problem?

Is it a program? I guess that's a two. Yeah, so, this again, probably one of the things, outpatient and inpatient that we see just every single day, all day long.

Understanding Pediatric Fevers

You know, and I like to remind parents that the fever is the body's reaction to something happening, right? So we just are coming through and never ending the real season.

Right. So, yes, your kid was forever. It's still going 30 days and 30 nights in the Bible. This was way worse than that. Still happening. You've got the sniffles and now all of a sudden there's fever.

Most parents, the biggest concern is the number, which is pretty much never my concern. The only thing I really get concerned about is, so one of my pet peeves is a parent comes in, they had a 99 Fahrenheit fever, and I'm like, no.

So in our world, 100.4 Fahrenheit, 38 Celsius, anything below that. And they're like well they usually are no, right? I know my child's body. That's the main thing.

And look, I'm probably going to develop hate for that because it's a common refrain that we hear from adults. I don't know, my body, this is a fever. You might feel bad.

Right. you feel that I am not denying that. Is your logically and clinically speaking, is it a Fever? No. is your body elevating its temperature? Yes.

that's where we need to figure out, okay, why is that elevates temperature above its normal set point? clinically, Is it fever in our sense? no. And, you know, the times when that matters is very tiny little babies, right?

So the neonates and that is important. Yeah. So, these, guidelines have changed and I'm honestly expecting the way that like the world and vaccine rates are right now that these may change again, but.

Don't worry, I already gave the political disclaimer a couple of episodes ago, so it is what it was. So I do expect that this might change. But from our standpoint, we don't like to do things and hurt little babies if we do not have to.

Tiny little baby, specifically babies less than 28 days old, babies that are not vaccinated, those kind of things, they are more at risk for serious bacterial infections.

A fever is not just a fever when it's a tiny baby like that. That a baby that is 18 days old had a rectal temp of 38.5, then it's like, okay, well then we're doing this, right?

What are we doing? Yeah, what are you doing to your baby at 18 that has a fever? We don't like to do so basically like poking them in all the places. So they're getting labs.

Um, they were getting for blood cultures. They're, getting urine, which is going to be a calf urine and they are getting, uh, a lumbar pump and a catheter.

That's when we stick the tube inside. Yeah. And then, you know, the needle in the back of a very tiny baby. And there's the lumbar puncture. Yeah, so that's what I discuss with parents, too, is listen, if you're coming in and you are telling me your neonate, your infant, had a fever at home, a lot of times they don't actually check it.

They don' have a rectal thermometer or any kind of thermometer. So they said, I checked them and they felt warm and the comment and their 20 days old and I'm like, all right, we really need to investigate this here.

We do an actual rectum temperature as normal. And then the parents will still say, well, they still have fear. Like, listen, you're telling me that they have a fever, clinically a, fever at 20 days old.

That entails an IV line, blood work, antibiotics. I don't care that we don' have any results, but you are getting antibiotics and a lumbar puncture where I stick a needle.

Well, for needles, it's probably like yay big. But for adults, yeah. into your child's back to drain fluid. That's what, if you're telling me that they had a legitimate fever, this is what we're doing.

And they, as I talk, their eyes start to widen more and more. Right. They realize, oh, yeah, no, let's not do that. Wait a second. Let's think about it.

Yeah, exactly. If we have to, we do those things. But that is the time when the number is something that I'm really fixated on. So to that end, what number scares you outside of the 30-day infant window, right?

Yeah, so just like a regular old kit. A regular six-year-old comes in. Honestly, there's not a number, which sounds kind of crazy. But in our training, we talk a lot about how some kids can tolerate really high fevers.

And I know that our grandparents told us that your brain will cook itself, but it's outside of something outside the body being wrong. Heat stroke. That's the key.

Yeah, that's something I like to bring up because it's, you know, the kids who are left in cars and hot cars that can get their body temperature up past the point where there's nothing.

There's going to be laws about that right now for that reason too. Yes. And so that or something, other things that are physiologically happening outside of the body.

Drugs. Yes. Let's be honest, there are parents out there who are bad parents and objectively bad parent, not the people who feel they're bad, parents, definitely bad.

Parents who leave things like amphetamines and their kid gets into it. And all of a sudden now, now their temperature is legitimately like one away. Yes, So that's different.

Yes. I tell people, your body has a set thermometer. Your body will not rise above that set thermometer by itself. It has to have external forces. So yes, if your child has 104.5 degree fever, and I look at the kid and they're running around like, you know, making a mess of things.

If I have a 104 degree, I'm on my ass, literally on. That's the end. Don't talk to me. Yeah. And so there's not, there is not a specific number, you know, again, it's, going to be more about like, how does the kid look and why do we think that this is happening?

Right. I think the fear for parents is this. Like I said, they think the brain is going to get cooked, but also the truth,

the real fear of febrile seizures that parents have heard about and then that's the thing in their brain that if they get to this number, there's going be a febrale seizure.

And that is not- That is a very common. Yes. That's a common reason for why we see kids in the ER as well is they had a seizure and we always want to say, well, was it a February seizure?

And most of the time it was.

When Fever Needs More Workup in Babies

We checked the temperature, it's elevated. Two questions, really, something from this. First of all, how long does a child have your phrase? How long are you OK for a trial to have a fever?

At what point do you get concerned that, hey, my child has had a fear enough for two days, three days? Seven days. What's going on? So this is a really good question because for my training in the pre covid era, five days was our kind of threshold because then we started thinking about things like Kawasaki disease and like So in our head, it was kind of…

That's going to be a whole other topic. You just need the motorcycle. We'll have to talk about that later. Yes, you'll bring me back for that. So five days was like this number in your head.

But in a post-COVID world, where some of these viruses now that we're seeing, especially at kids who were in quarantine for a while, and now all of a sudden they went to kindergarten for the first time or whatever, they're getting viruses and they are having fever five, six, seven days, but they look okay.

They look good. They're happy and they're doing whatever their thing, but then randomly they'll spike a fever, right? So if that's happening, if you're at four or five days, I mean, you definitely need to be seen by your doctor.

You definitely have some kind of exploration for why it's happened. Right? But two days and you are eating and drinking. I'm not stressed about it. Three days you eat and drink, fine.

parent brings their child to the ER, five days of fever, no symptoms. They're not coughing. There's no runny noses. You check the ears, there's nothing there.

And there is no vomiting. Now what? Like in my legitimate, is the parents, they come to they ER. The parents are saying, I've had, my child's had a fever for five day.

Check this fever at 99.1, but 101.5 gets better with Tylenol. and now, now what, should they expect that we're going to do blood work or lumbar puncture?

Yeah, so, I mean, that obviously is going to be kind of a clinical call for each doc, but the fever on its own is not the thing, right? In a healthy, well-appearing kid.

And so common things being common, they've got a weird virus that's just not showing the sniffles, like kids are exposed to everything in their daily lives.

You know, sometimes everything goes in the mouth. Everything goes up the nose, the ears, whatever. And a lot of times they're doing it like they've got two viruses happen at once or they just had one and now they got another one like piggyback.

So those kind of things are the most common reason that this is happening. Right. Yeah, there's a joke I like to make called Hickam's dictum. The patient can have as many diseases as they want.

It's not like, hey, you got the flu. All right, well, sorry, COVID. Sorry, rhinovirus. We're full right now, we can't admit you. They're going to come in anyway.

And they're gonna come into the middle, the end, doesn't matter. That's what a lot of parents who send their kids to daycare realize for the first timers, like my child is always sick.

Yeah they have a virus. Yes. The whole time. Also true. That's also a thing. Yes. My daughter, my daughter is going to be four. She's probably had a runny nose since she started daycare at six weeks.

So it's, you know, like it just been constant. It just keeps going. And it was just, that's how she is now. But it not necessarily the timing. Like obviously if there's prolonged fevers, we're going start to look around for a reason for it a little more.

Again, it is not something that is, oh my gosh, panic. We're gonna go do all the things and it automatically the worst thing because the most common thing is gonna be some virus.

Yeah, and like you said, common things being common, that's what we say in medicine a lot. At the end of the day, we're looking at more common days. We're not looking beyond common.

And there are certainly uncommon things out there that children are going to have that are gonna be missed. Not for nothing, We are to miss that the first couple visits until the routine testing has already been done.

Your doctor is not an idiot for missing that. It's just we have to look at common thing first before we look the zebras. Otherwise, every kid's getting a needle in their back and nobody wants them.

Yes. Now, you mentioned the guidelines. What guidelines are you talking about as far as fever goes? So, there's AAP, American Academy of Pediatrics comes out with the guide.

Fever Duration, Testing, and Common Causes

A lot of the hospitals that we have are following CHOP, Children's Hospital, Philadelphia guidelines, and P's were real big on algorithms and stuff like that of trying to standardize these things for the kids so that were not doing the unnecessary testing.

And that's the key is unnecessary testing at the end of the day. We likely know what's going on, but we want to minimize your kid getting poked and prodded.

So these are protocols that everybody follows, not just pediatricians, emergency medicine, hospitals, whatever. Right. There's a lot of work that goes into them and a of research, which is like.

I feel like a trigger word these days, but there's a lot of that is happening behind the scenes to sort of adjust where at some point it was every kid under two months old is getting this full work up and then it's every kids under 40 days and that's everything under 30 and now we're at 28, right?

And there are all these kind of levels of it, which is great, because it means we are getting better and better at kind and narrowing down the kids who absolutely have to do all the tests, right?

And we're able to do that because we are kind of doing this research and finding out how often are we missing something if we don't do a lumbar puncture in a five-year-old with a fever, and we found we were really not missing that much.

There's usually something else, if there's something that they're showing us that causes us to want to go down that path, but it's not the fever itself.

Yeah, and the source of the fever is what our main concern is. Fever is a symptom. If we suspect a source to be a virus because everybody in your family had a fever and had the same virus, it's fine.

But, you know, like you said, neonates especially, they're immune compromised from the get-go. And that's when

we need to start looking at, really look at what's going on.

We give Motrin Tylenol to make the child feel better. Does that mean I need to give my child Motron Tylinol around the clock? Yeah, good question, because that is something that we used to do, right?

Especially, you know, if we had kids with febrile seizures and then we were sending them home, we are like, OK, give, tell Motran and. Again, research, so important, has been coming out showing that this doesn't really change the risk of them having another febrile seizure, right?

It does help to keep them comfortable. There is some data about that it can be confusing for parents. Like, which did I just give? Did I give Tylenol?

Do I gave Motrin? Should I stick to one, Risk of overdose. Right. I'm always going to hear, you know, the parents say, well, this works better for them or this one works for better them.

So in general, my recommendation is like, if the kid looks like they don't, they're looking a little punky. They're like not feeling really great. You can give them Tylenol or ibuprofen, right?

Correctly dosed to make them feel better. Um, and we dose it by weight. So that's the other thing too. Those, so I, as a father, I get the Tylenol and the Motrin and it says, uh, children under two, please consult your doctor.

Oh, great. Now what? Yeah. But now I obviously, you know, we both understand, okay, it's weight-based dosing. My child weighed this at their last checkup.

I can at least give them this. And that's something that parents should know as well. And ideally, that is where the calls to the pediatric office come in.

Like, hey, my child has Motrin. Hopefully, somebody in the office or clinic or whoever can say, your child weighed this at their last visit, it's okay to give them 5 mLs or this syringe full.

Exactly. And again, it's, you know, this is not curing anything. It is making them feel better. And we often get parents who come in and say, I gave my child Motrin, the fever went down, and now it's back again.

Now what? And the answer is, it is going to come back. Until whatever stimulus, whatever infection is causing this fever, your fever will be there until your body reaches a point where it has beaten down that infection enough that it doesn't need to spike that fever.

Here's a question for you. I don't know if you know the answers to this. Are we over treating fever? Should we let fevers run? Yeah, so I think we probably do, you know, because there is not a reason in a kid who's not feeling bad to necessarily be giving it around the clock, right?

So I do think that parents obviously don't want to see their kids being miserable. They also get scared when their children are sick. Right? And this is like a relatively benign thing in their mind that they can give to help make it better.

Right. And it's something they usually have in the house. They don't have to go see their doctor. I don' necessarily care if you took the temperature.

So especially in a kid that we know has something like fever. Let's say you got something, like, a virus. You have a kids who's five years old, cough, runny nose, they're fine, but they've got a fever, we assume it is whatever virus, doesn't matter.

Um, the virus of the week that they have. And so I don't need to know that it, that there were 101 or 102. Like it doesn't matter if you feel them and they feel hot.

Cool. Fine. If you want to give the Tylenol and like you didn't just give it before and you have it and it's appropriate. You know, are we over treating it?

Yes, probably. There has to be something somewhere along the lines that, alright, our body's raising its temperature for some evolutionary advantage to warm it enough to kill whatever virus is in there.

I've seen some YouTube videos and articles regarding it and they say, well, treating the fever may prolong the illness time. may prolong the illness time and that is because your body is mounting some defense, it's a defense mechanism against an insult that evolutionary speaking has benefited us in the past.

So why are we preventing that from doing its job? And the argument makes sense to me. And that's kind of what I say to parents too, in a way that I said, look, it's up to you if you wanna treat the fever.

I'm not telling you to treat this fever, you're not preventing anything bad one way or the other here. With my own kids, if my kid has a fever and I know they have a fevers because my daughter got ear infections all the time when she was super little, so I knows she had an ear infection.

Treating Fevers, Medications, and Home Care

doesn't seem to bother her at all. She's running around being a crazy kid. I'm not going to treat it, right? If she is like crying. You're a bad mother.

No, exactly. A bad pediatrician. When she's curled up on the couch and she just looks so sad, I am like, oh, you need some Tylenol. Again, we're going off vibes here.

This is not science-based. Kid feels bad and when kid feels that mom get sad and so I'm giving you Tylenol, right? I like that. When kids feel bad, mom gets sad.

But again, I probably give less Tylinol to my kids with their fevers than a non-pediatrician parent because it just doesn't worry me as much. And I think there's a lot of parent shaming out there on social media, especially the last several years.

So I thing it's also important to say that if you want to give your child medication, do it safely. Do it under the consultation with a doctor and that's fine.

If you don't, you're not causing them harm either. Right. It's whatever you feel is best for your children. Exactly. And if they have questions, people like you are always here and me are here too.

Great. I feel like a lots of things, there are cultural and generational things that people believe work for their for fevers or colds or coughs. And most of the time, I don't care.

If you want to put, you know, Vicks on the bottom of their feet before bed, that's totally fine. I So that's a good question. Usually I don't have anybody do it under two, just because two is like an age for me, but they probably say one or something on the jar.

Does it actually stay in the bottle? Yes. I wasn't sure. If it's on a feed, it is different, right? So like when, you know, where they're breathing it in, I Almost never recommend it just because some kids can like easily be triggered in like allergies Yeah, exactly.

But again in an older kid That that's not gonna worry me so much if they want to do like, you know a cool bath again That's fine. If you want do it. I don't put your kid in the nice bath, right?

It's gonna make it better. It means I'm like if you wanna do a cold bath fine Also, probably not going to make a better but not harmful, right? They may liven up too, the water they're splashing, they may have a little bit of fun.

Exactly. There isn't always a scientific answer for some of these things, which makes us as like scientists very uncomfortable. But in general, if I can like be assured that it's not dangerous, then you know.

Yeah, at the very least, obviously we're scientists, but our first part of our oath is do no harm. So as long as it's not causing harm, then that's fine.

Do what you feel like you want to do. And if you're telling me it made your kid better, awesome. I'm glad that your kids doing better. One final question before we go here.

Is there a temperature where you consider antibiotics? Good question. No. I mean, again, outside of the neonate, never trust pathway. Yeah. If we're going just by vibes, if we are just like, hey, my child.

There is not. Has that been shown by research or is that more just… Oh, so that's a good question also. So things that… Yeah, because if it had been showed by a research, then it would be on these serious bacterial infection pathways, but there's really not a great correlation to it on fever alone, right?

We have correlation with all the other things, inflammatory markers, that kind of stuff. When we're going down the blood work route, these markers that we check on the Blood Work are going to guide us about antibiotic usage or not.

So if your child's sick enough that you're getting Blood work, there's a non-zero chance you are getting antibiotics. But beyond that, just because you have a 104.6 or 106 fever doesn't mean you need it.

playing, then it doesn't mean right. Like, your infections can give super high fevers, they're going to get antibiotics. Viruses can get super-high feivers, and they are not going I think that's just one takeaway from this episode.

Final Takeaways and Show Outro

It's we go on vibes, ladies and gentlemen. Maggie, I'd love to have you back on here. There's a lot more in the pediatric world to discuss. If you think of an idea, if our viewers, listeners have any ideas for future, they want clarification, please feel free to reach out especially.

So, but Maggie thank you so, so much. Thank you. Glad to be here! Alright, well that wraps up another episode of the Jaffercast. Thanks again to Dr. Maggie Gorin, pediatrician joining me this week to talk about pediatric fevers.

If you enjoyed this episode, please don't forget to like and subscribe and turn on notifications. We are on YouTube and Spotify with more platforms to hopefully come in the future.

I love constructive feedback and ultimately, this show is to help you the listener or viewer make informed choices with regards to your own health and to raise awareness about the issues facing healthcare at large.

You can leave your thoughts in the comments below for those who are on YouTube, or email them to me at jeffordcast at gmail.com. If you're in a healthcare field and you are interested in being on the show to discuss topics in healthcare, please feel free to reach out as well.

Or if there are topics that you want to hear more about, Please email to them me. I'm always open for suggestions. As with anything though, don't take my word for it.

Do your own research, talk to your doctor, and remember, at the end of the day, I am just another fucking ER doctor. Make your choices everybody, we'll see you next time.