ADOLESCENT HEALTH ACADEMY, KERALA

e -journal

ADOLESCON 2018

Adolescence is a new birth, for the higher and more completely human traits are now born.

G Stanley Hall

ADOLESCON 2018

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What's Inside...?

Adolescent Obesity

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Adolescent obesity is a common clinical problem faced by a pediatrician. It results in development of cardio metabolic complications, both, in adolescence and in adulthood .The Harvard Growth Study found that boys who were overweight during adolescence were twice as likely to die from cardiovascular disease as those who had normal weight.Height (in cm) is measured by a calibrated stadiometer and weight (in kg) is measured on an electronic digital weighing scale and Body mass index (BMI) is calculated using the formula BMI = Weight (in kg)/ Height (in m^2). Interpretation of BMI to diagnose obesity is an area of controversy. Conventional definitions of overweight and obesity include BMI > 85th percentile and BMI > 95th percentile, respectively.However, childhood obesity is known to track on to adulthood and extensive evidence is available on the cardiometabolic risk in obese adolescents. Asians are prone for metabolic riskat lower BMI. Hence, the Indian Academy of Pediatrics (IAP) in 2015 came out with charts and cut-offs linked to adult cut-offs of 23 and 27 kg/m2 as overweight" and "obesity".obesity can be easily picked up by plotting BMI in growth chart with BMI percentiles. IAP designed mobile app named “IAP growth chart, which can be downloaded from IAP website is a easy tool to diagnose growth related problems in office practice.

As adolescent obesity results in development of cardio metabolic complications, both, in adolescence and in adulthood.It is the responsibility of the primary pediatrician to recognize adolescent obesity prior to the development of cardio metabolic complications.Even though endocrinopathies and genetic syndrome may lead to obesity,the commonest cause of adolescent obesity is nutritional. A through history and clinical examination is essential to exclude the genetic and endocrinecauses. Height< 3rd percentile or short stature, delayed bone age, growthvelocity less than 25th percentile, hypoplasticgenitalia, Menstrual irregularities beyond first year after onset of menarche,polydactily,visual impairment,severe hypertension (BP > 99th percentile),focal neurological deficit are redflag signs, which points towards a endocrine cause or genetic syndrome.Metabolic syndrome,Type 2 diabetes, Hypertension, Hyperlipidemia,Nonalcoholic fatty liver disease,poly cystic ovary syndrome are the common metabolic co morbidities.Obstuctive sleep apnoea,slipped capital femoral epiphysis, blount disease (tibia vara),musculo skeletal pains,pseudo tumor cerebri,gall bladder disease, migraine,behavioral complicationsand asthma are other associated morbities..

Management includes, Dietaryrestriction, Behavioral change,Exercise,Drugs, Bariatric surgery.

Diet & Behavioral change is the main stay of the treatment.

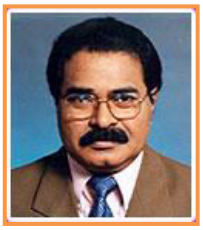
- It is important to begin with clear recommendations about appropriate caloric intake for the obese child. Working with a dietitian is very helpful.
- Meals should be based on fruits, vegetables, whole grains, lean meat, fish, and poultry. Prepared foods should be chosen for their nutritional value, with attention to calories and fat.

- Foods that provide excessive calories and low nutritional value should be reserved for infrequent treats.
- Weight-reduction diets in adults generally do not lead to sustained weight loss. Therefore, the focus should be on changes that can be maintained for life.
- Attention to eating patterns is helpful. Families should be encouraged to plan family meals, including breakfast.
- It is almost impossible for a child to make changes in nutritional intake and eating patterns if other family members do not make the same changes.
- Dietary needs also change developmentally, as adolescents require greatly increased calories during their growth spurts, and adults who lead inactive lives need fewer calories than active growing children.
- Psychological strategies are helpful. The “traffic light” diet groups foods into those that can be consumed without any limitations (green),in moderation (yellow), or reserved for infrequent treats (red)
- The concrete categories are very helpful to children and families. This approach can be adapted to any ethnic group or regional cuisine.
- Motivational interviewing begins with assessing how ready the patients to make important behavioral changes.
- The professional then engages the patient in developing a strategy to take the next step toward the ultimate goal of healthy nutritional intake. This method allows the professional to take the role of a coach, helping the child and family reach their goals.
- Other behavioral approaches include family rules about where food may be consumed; for example, “not in the bedroom“ or No food While watching television.

- Pediatric providers should assist families to develop goals to change nutritional intake and physical activity.
- They can also provide the child and family with needed information.
- **The family should not expect immediate lowering of BMI percentile related to behavioral changes, but can instead count on a gradual decrease in the rate of BMI percentile increase until it stabilizes, followed by a gradual decrease in BMI percentile.**
- **Exercise**
- Increasing physical activity without decreasing caloric intake is unlikely to result in weight loss. It can increase aerobic fitness and decrease percent body fat even without weight loss. Therefore, increasing physical activity can decrease risk for cardiovascular disease, improve well-being, and contribute to weight loss.
- Increased physical activity can be accomplished by walking to school, engaging in physical activity during leisure time with family and friends, or enrolling in organized sports.
- Children are more likely to be active if their parents are active. Just as family meals are recommended, family physical activity is recommended.
- Active pursuits can replace more sedentary activities. The American Academy of Pediatrics recommends that screen time be restricted to no more than 2 hr/day for children >2 yr old and that children <2 yr old not watch television.
- Television watching is often associated with eating, and many highly caloric food products are marketed directlyto children during child-oriented television programs.

Although there are specific indications for drug therapy in adolescents with metabolic complications,diet and exercise are the main modes of therapy for all obese adolescents, even though Metformin is indicated in metabolic syndrome it is not a substitutefor diet and exercise. If given as a first line measure, adolescents tendto have unrealistic expectations and do not adhere to dietary and exercise regimens. Hence, metformin is started as a measure after ensuring some weight loss with dietary restriction and physical activity at least for 3 months.

Dr MKC Nair Oration



Professor M.K.C.Nair: *Founder Director of Child Development Centre, Thiruvananthapuram and now "Professor Emeritus" in Developmental, Behavioral & Adolescent Pediatrics in Child Development Centre.Along with his medical degree in Pediatrics, he has acquired various degrees in medical and other science branches- M.Med.Sc. (Epidemiology) from University of New Castle, Australia, PhD from University of Kerala, Masters Degree in Philosophy and religion and Mass Communication. He also holds an MBA in Hospital Management.He has been faculty of CERTC, Chairman, and Board of Studies in Health Sciences, University of Kerala, and Member of editorial boards of IJP, Perinatology and Journal of Neonatology. He is the academic editor of IAP Textbook of Pediatrics and member of International editorial board of Vulnerable Children and Youth Studies, UK.He has delivered the prestigious Shantilal Seth Oration of IAP and is a recipient of Lifetime achievement award of IAP and 9th AIWEFA Nina Sibal Memorial Award. He was made Vice Chancellor of KUHS in 2014. His integral and intimate relationship with IAP has resulted in his becoming National President way back in 2004. He was also National President of NNF and India CLEN.His moment of crowning glory has come in 2018, when he was given* ***DSc.*** *from University of Kerala, its only second DSc, for his study of ' 25 year prospective follow up of babies with intrauterine growth restriction in a teaching and tertiary care hospital' in South India.*

Dr Shaji Thomas John being awarded with the MKC Nair Oration award

Communicating with Adolescents

Dr Shaji Thomas John
Sr Consultant in Pediatrics-BMH, Kozhikode.
Former National President, Adolescent Health Academy

Communication means Imparting or exchanging of information by speaking, writing, or using some other medium. The methods used for communication over the ages have been many. Smoke signals and carrier pigeons used earlier are only of historic interest. The telegraphs have become extinct and the use of surface mail is dwindling. Dial up internet has come in to stay. Landline telephones do still exist, but the mobile phones and smart phones are now dominating the scene.

Communication can be classified into different styles, modes and types: They can be passive, aggressive, passive-aggressive or assertive. Communication can also be submissive or manipulative. They can be intrapersonal, interpersonal, group, public, or means for mass communication.

The mostly commonly used classification is Verbal, Visual (Books/Screens) and Non-verbal (including signs and body language)

Communication in Adolescents

For all communications there should be a 'sender' and a 'receiver'. For our topic we have adolescents as the 'receiver' and the effect of the communication can be modified by the age, mood and preoccupation of the adolescent. The 'sender' normally to an adolescent can be the parent, the teacher, the health personal, the peer or the media in general. For an effective

communication it is important that the 'sender' and 'receiver' must understand the same language whether it be verbal or non verbal. The vocabulary used matters a lot: LOL, OMG, ILY, AMA are common acronyms used while texting and words like lurker, clout, phubber and so on may sound like Greek and Latin to the uninitiated. We shall be discussing only about areas where the 'sender' is a parent or a health personal.

Technology and the young:

Surveys have shown that more than 75% of adolescents and young adults went online daily and about 90% of them use texting as a regular means of communication. This is in addition to the use of smart phones by a very large number, the statistics being brought down only by the early adolescents.

At this rate you may reach a stage wherein you don't have to talk to each other, the newspaper boy is replaced, the postman is replaced; you can order groceries and other merchandise through the net. Games are on tablets and pads, and you lose your communication skills, your fingers become dexterous, and you live in a virtual world. Even data can be exchanged when you meet someone without speaking.

And this can herald the death of verbal communication !!!

Media Use:

With the current rampant indulgence in media for communication, adolescents should be encouraged to strike a balanced media use with other healthy behaviors. It is our responsibility to make sure that media does not take the place of adequate sleep, physical activity and other behaviors essential to health. Teens need adequate sleep of 8-12 hours a day, with adequate physical activity of about an 1 hour. Time away from media is mandatory.

Media-free times together (e.g., family dinner) and media-free zones (e.g., bedrooms) should be designated.

As health personals we should take a media history and ask three 'media questions' at every well-child visit:

How much recreational screen time does your child or teenager consume daily? (It should preferably be less than an hour)

Is there a television set or Internet-connected device in the child's bedroom? (should not have any in the bedroom)

How is your child's performance in school? (If it is deteriorating then monitor the screen time and activities)

Communicating with adolescents by parents:

Parenting styles affect communication. The different types of parenting affects the communication process and its effectiveness:

1) Authoritative parenting: It is supportive as well as demanding and there is bi-directional communication.

2) Neglectful: It is unsupportive and undemanding and the communication is uninvolved

3) Permissive: Supportive but undemanding; is low in controls and communication

4) Authoritarian: Demanding but unsupportive; resulting in uni-directional communication

Each one carries different characteristics and brings about different effects in children

Advice to parents for an effective communication:

Do NOT threaten them; or yell at them; or compare them to someone else, or spy on them. They should feel that they can communicate with you at any time. If the teen slams the door in your face, this is basically what it means: "I'm mad, and I want everyone to know, and most importantly, I HATE YOU!"

But they don't mean it, it's just the way it comes out

Communication by health personal:

The environment should be conducive to mutual respect and trust, enabling free and open communication and understanding. We should welcome them, smile, be pleasant and friendly in nature.

Allow them to speak; and practice the art of listening. Be sincere and tactful and show a genuine interest in his/her needs. We should be sympathetic and understanding. Avoid interpretations and giving advice; and maintain the confidentiality. The body language of the health personal is very important to establish and maintain a proper rapport.

Communication in a crisis requires skill and empathy. It is any situation wherein a person does not have adequate coping skills. Crisis varies from person to person and from time to time. What is not a crisis now may become a crisis later. Offer emotional support and provide opportunities for catharsis. Communicate hope and optimism.

Common errors in communication

Blaming the child, and being indifferent to the child's feelings should be avoided. Interrogating the child, judging and evaluating as well as preaching and patronizing the thoughts and actions are equally bad. Communication is an

art and a science which helps in the relationship building process. And for health personal and at times for others; it is a treatment modality

Remember to 'Walk the talk before you talk the walk'

Myths & Misconceptions about Masculinity

Dr Newton Luiz
Sr Consultant in Pediatrics Dhanya mission Hospital, Thrissur

This is the era of Me-Too, a time of increasing awareness of sexual harassment and molestation and rape. It is often noted that in a discussion of this sort males as a whole are frowned upon as perpetrators of atrocities. But all men cannot be deemed monsters, and this negative viewpoint can be counterproductive. While the rapist should be savagely denounced, the very commonness of eve-teasing and even domestic violence indicates that one must change destructive social traditions and attitudes if one is to eradicate the problem.

The Male as a Social Brat

A 3 year old child is brought to the hospital with a fever or cough, and the doctor witnesses the angry child pinching or biting his mother repeatedly, while she tolerates his horrible behaviour with a half-smile. The caretakers of the child believe that he is 'only a child' so whatever he does is acceptable, and they refuse to punish him as they 'want him to be happy'. The child grows up a brat, having his own disgusting way within the confines of his house. He is a bully in school, snatching whatever he wants from his peers, and pinching or biting them – and he cannot understand why they all hate him and fear him – after all such behaviour is accepted with a smile at home – and he concludes that society is against him. As an adult he will find that at work instead of bossing around he has to obey instructions. He will bully his wife and children.

His parents' refusal to teach him right from wrong has made him an angry ~~and~~ frustrated and miserable adult.

While the above story is not so common, and while it applies equally to male and female brats, a lesser variant is repeated routinely in most households even today, and applies only to the male child. His parents believe that boys should be "dashing daredevils", mischievous, naughty, saucy, and aggressive; they need not be clean or neat or tidy; they should not do any work at home. They misconstrue mischief in their sons as a sign of intelligence, and they are confident that boys will outgrow their mischief. Girls, on the other hand, are meant to be "dainty darlings", obedient, quiet, and submissive. They should always be clean and neat and tidy; they should help their mother at home. Is it any wonder that a boy's hostel room is usually a mess and often unclean; that the adult male is not much better, and expects his wife to clean up after him; that many confused males are despondent about the need to work for a living, and take out their frustration by hitting the bottle? The desperate desire to dominate means that the husband will demand that the wife hand over her salary to him, and insist that she is not competent to drive the car, and may even use physical violence against her.

Atrocious behaviour in the adult has its origins in the child. A brat is a brat because his parents failed to discipline him, to teach him right from wrong. The dominating and aggressive adult male was taught by society, right from his toddler days, that the male has a right to dominate. The submissive female has been trained to be submissive.

Fortunately such attitudes can be changed through education, and through a change in social values, and they are already changing. Co-ed schools unconsciously change these perceptions by treating boys and girls alike. Women are entering the workforce in increasing numbers, and seizing jobs

that were once the sole preserve of the male, attaining financial muscle and becoming increasingly independent. As inequality decreases male-female relationshipsmay initially be stressed by the increasing freedom of women, but graduallyit will improve and both sexes will benefit.

SOME MISCONCEPTIONS ABOUT MASCULINITY

Here we discuss some basic misperceptions that are common among males. Clearing such misconceptions is a necessary step towards mature male-female relationships.

Expressing emotions

The male adult believes that it is shameful, or at least a weakness, to express sorrow in public. He is permitted to express joy – or anger. And when under stress he may break out in anger because he cannot admit openly that he is stressed. If a patient dies of a heart attack in hospital the female relatives will mourn quietly, but the male relatives may actually get angry and even destroy hospital property. The male often feels acutely embarrassed about expressing love and affectionwith his wife in private– and even with his children.

Relationship with children

A doctor was once talking happily about how much he enjoyed playing with his 6 month old baby girl. Then he abruptly and sadly said, “But I know it is wrong to be so friendly with her, because if I continue like this she will not respect me as she should when she grows up”. He believed that children should fear their father, but were free to love their mothers. He had to be convinced that respect born of love is better than respect born of fear, that a 6 month old child needs to be played with, and that it is simultaneously a father’s solemn duty and great delight to play with his children.

Sex as competence

Strangely, one reason that young adult males visit CSWs is because they worry that they may not be able to perform the sexual act properly, and so they wish to have a practice session. This is the worst type of initiation one can think of, because it involves performing under the pressure of time, and that too with a stranger. Even within marriage men may be so obsessed with their performance that they become tense and even impotent. Premature ejaculation is not uncommon, and is often due to performance anxiety.

Sex as power

In adults eve-teasing and molesting and rape is about power rather than sex. That is why even infants and the elderly are victims of sexual crimes. It cannot be a great sexual experience to rape a toddler, yet even infants are raped. Such atrocities are mostly committed by anti-socials who have a desire to dominate.

EDUCATING THE MALE ADOLESCENT

Here are some points to be discussed with the adolescent male in our Family Life Education classes, to equip him to understand girls better.

1.What do girls find attractive in boys?

This is a common query from the boys. Many of them believe that since boys are more obviously muscular then girls, girls will be strongly attracted to a muscular body. They need to know that while there is nothing wrong with going to the gym and building up big muscles, girls are unlikely to be as impressed by the results as other boys. What really attracts girls to boys is

a. Boys who are decent, who treat girls with basic courtesy and respect.

b. Boys who are good in studies, sports, cultural activities. Everyone likes a winner. Boys who do well in studies, far from being perceived as 'boring mugpots', are recognized as those who are most likely to succeed in the future in studies, at their job, in their life.

c. Boys who are friendly without being romantic.

d. Boys who are cheerful. No one much cares for a sad-faced person.

e. Good looks are a definite bonus, but not essential.

2. Eve-teasing

This often arises from the inability of the shy boy to interact with girls. He is more likely to indulge in eve-teasing when in a group. He decides that a negative interaction is better than no interaction at all. He is hoping that she will notice him, and that she will make it easier for him to approach, perhaps even make the first step herself. Eve-teasing is a euphemism for sexual harassment. It usually involves benign or humorous comments, but can deteriorate into sexual innuendo or nasty remarks. The boy needs to be told firmly that girls consider this to be indecent behaviour, and that the only way to interact with a girl is to approach her in a friendly manner.

3. Molesting

This involves touching a girl against her wishes. It often occurs in a crowded bus or a busy street, or in a dark place such as a cinema theatre. The victim may pretend not to notice, or try to slink away with a false smile, especially if the boy is someone she knows. But this is something that girls absolutely detest, and among themselves they talk of such guys in very harsh terms. Such behaviour will seriously damage a boy's reputation among the girls.

Boys frequently deceive themselves that girls actually like such approaches. They say that as girls like to be noticed by boys they probably secretly enjoy the eve-teasing. They even suggest that girlsmay enjoy being molested as they too have sexual needs. During a discussion on molesting girls in a bus, an unmarried doctor once asked in all seriousness, "But if I do not do such things, how will the girl know that I am interested in her?"

4. Pornography

Boys watch pornographic videos to satisfy their curiosity about sex. Unfortunately such videos routinely depict sex as a primarily or solely physical act, and the gullible adolescent comes to believe that this is all there is to sex and male-female relationships. He starts seeing all girls and women as sexual objects rather than as individuals with feelings. Even after marriage he is under the impression that once he performs his 'sexual duties' his wife should be quite satisfied. That is why pornography is so harmful, because it deceives boys at an age when they are very impressionable. They need to know that sex and coitus is a glorious experience, **but only when it occurs upon a strong foundation of love**. Sexuality requires, first and foremost, a strong emotional bond. Happy interaction with girls demands that one shows them basic courtesy and behave in a friendly manner. A happy marriage requires the ability to show love and affection to one's wife.

5. Commercial Sex Workers

Another risky technique by which boys satisfy their curiosity about sex is by visiting a CSW. This is possibly the worst introduction to sex as the act of coitus is purely physical, and the CSW is in a hurry. It is often an unpleasant experience, and can even be a humiliating one. Worst of all, there is a high risk of catching a sexually transmitted infection. This is most commonly gonorrhoea, but HIV in Kerala is spread primarily by CSWs, a high percentage of whom are infected with it, as they have multiple customers daily.

THE MALE AS VICTIM

It is important to realize that the male too is a victim of these negative social customs.

1. Child Abuse is experienced differently by the male and female child. The male child experiences a lot more corporal punishment than the female in

every part of the world. Data on sexual abuse suggests that it is much less in developed countries, and primarily a problem of the girl child. But in developing countries the incidence is higher and the proportion of males who are sexually abused increases dramatically. This may be because girls are more carefully supervised and more restricted in their freedom. Data from our country is scanty and unreliable, but suggests that males and females are equally liable to be abused. In Afghanistan, the majority of male children experience some degree of abuse.

Homosexuality is not approved in our society; anecdotal evidence and newspaper reports suggest that they get access to male children by befriending them and tempting them by taking them to movies and restaurants or by offering gifts and money. Criminals introduce them to drugs like marijuana, and once they are addicted to it they encourage them to make easymoney by becoming drug pushers.

2. **Smoking, Alcohol and Drug Use** all start most commonly in adolescence, and are far more common in the male.

- **Smoking** was once considered a sign of masculinity but is fortunately going out of fashion today, as the adolescents are aware of its health consequences. This is one good example of how social attitudes can be changed through education.
- **Alcohol use** is yet another fashionable initiation into adulthood for males. In its avatar of 'social drinking' it is socially accepted and even approved, even while drunkards are disapproved of. One conveniently refuses to believe that 5 – 10% of social drinkers eventually become alcoholics, and that there is no way of predicting who will be the next victim, as half of them have no predisposition (such as a personality disorder or a psychiatric problem).

- **Drug abuse** is fortunately not socially approved, but may follow alcohol use. Initiation is with chew tobacco (pan parag) and marijuana.

3. **Road TrafficAccidents** are primarily a male phenomenon. Males are much more likely than females to use a bike or car, but even after adjusting for this fact females are still statistically much less prone to accidents than males. This need not mean that they are more skilled drivers. It may be due to higher testosterone levels in the male, his use of the vehicle as a status symbol, his 'need for speed', his rage on being overtaken.

4**. Accidental Drowning** is a regular tragedy in Kerala that disproportionately affects male adolescents. The adolescent thrills in being a daredevil, and believes that he is invincible; he takes risks even in treacherous waters, during heavy rains, and in stormy weather.

5. **Heart Attacks and Strokes** occur more frequently and earlier in the male, and in every society there are more widows than widowers. While this may partly be due to the protective action of estrogens in the female, it has now been shown that much of it is secondary to smoking and alcohol use.

6. **HIV-AIDS** can spread by many routes but in Kerala the vast majority get it through contact with commercial sex workers (CSWs). Other routes are being brought under control in Kerala: blood transfusion is never given without testing, only disposable syringes are used nowadays, all pregnant women deliver in hospital and are tested for their HIV status during pregnancy and treated if necessary; HIV positive mothers are discouraged from breastfeeding; IV drug use is fortunately not (yet) a major issue in Kerala. The tragedy is that contact with CSWs is most commonly initiated in adolescence or early adulthood. It then spreads from the infected male to his wife, and occasionally to her child.

CONCLUSION

One's best friends are one's peers – not ones bosses or subordinates. Intimacy cannot be achieved with someone who is not one's equal. Happy relationships before marriage, and a happy married life, can only occur among equals. Co-ed schools are a great blessing as they permit adolescent boys and girls to interact in a healthy manner, and constantly prove that girls are on par with boys at all levels.

Sexual Abuse- Do's & Don'ts for a Pediatrician

Dr Sonia Kanitker
Joint National Convener, Medicolegal Chapter Central IAP.
Senior consultant in Adolescent and Child health.

- **Definition:**

  Sexual abuse occurs when a child/adolescent is engaged in sexual activities that he or she cannot comprehend, for which he or she is developmentally unprepared and cannot give consent, and/or that violate the law or social taboos of society. The sexual activities may include all forms of oral-genital, genital, or anal contact by or to the child or abuse that does not involve contact, such as exhibitionism, voyeurism, or using the child in the production of pornography.

- Sexual abuse need to be differentiated from "sexual play".

  When young children at the same developmental stage are looking at or touching each other's genitalia because of mutual interest, without coercion or intrusion of the body, this is considered normal (i.e. nonabusive) behavior.

  However, an 8-year-old who tries to coerce a 5-year-old to engage in anal intercourse is displaying abnormal behavior"

PRESENTATION OF SEXUAL ABUSE IN OUR PRACTICE ??

- 1) The adolescent (he or she) has made a statement of abuse or abuse has been witnessed by the teen.

- 2) The adolescent is brought by social worker or lawyer /police medical evaluation for possible sexual abuse as part of an investigation.
- 3) The adolescent has come to an emergency department after a suspected episode of acute sexual abuse.
- 4) The adolescent is brought by care giver because of behavioral or physical symptoms.
- 5) The adolescent is brought for a routine vaccination, and during the course of the examination, behavioral or physical signs of sexual abuse are detected.

THE DO'S AND DON'TS FOR US,PEDIATRICIANS ?

1)We do not need police requisition for managing

2)Its a Medico legal Emergency

3)Any clinical establishment , either government or private cannot refuse to manage the victim of sexual assault/abuse

4)All the first aid medical expenses has to be provided free

5) The registered medical practitioner rendering medical care shall

- A)collect evidence after a thorough medical examination,
- B)treat the physical and genital injuries,
- C)conduct age assessment of the victim (if required),

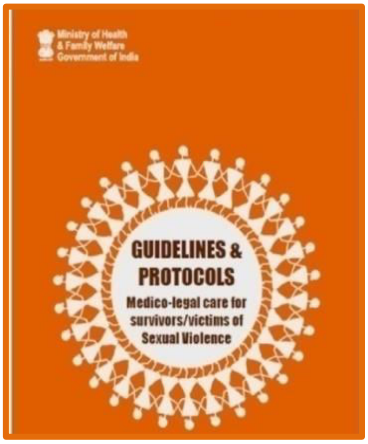
  D) offer prophylaxis for sexually transmitted diseases including HIV,

- *E)* discuss emergency contraceptives with the pubertal child and her parent,
- F*)* do baseline evaluation for mental health issues,

- *G)* monthly follow up at least for six months to look for development of psychiatric disorders,
- *H)* do family counselling and
- I*)* assist the court in interviewing the child and testifying in the court.

We all need to learn about the Guidelines and Protocols of Ministry of Health and Family Welfare and also about the POCSO Act 2012.

Let's learn the intricacies the legal way !!!



Victory over Learning Disorders

Dr Beena Johnson
Sr Consultant in Adolescent and Child health, BMH, Kozhikode

Introduction

Scholastic backwardness is seen in about 30 % of school going children. Common cause for scholastic backwardness in children and adolescents, is learning disorder. It is a cause of stress for children, their parents and teachers. Hence learning problems of children and adolescents should be identified and corrected at the earliest.

“My son got very low grades for all the exams. He is talented in drawing and sings very well. But he does not like to study, and he is not at all interested to go to school. Doctor, please help my son to improve his academic performance and make him a good student.”

This was the request of a mother who came with her twelve-year-old son to the child guidance clinic, last year. Academic skills of the child were evaluated. He was an intelligent boy. But there was significant impairment in reading skills, writing skills and mathematical skills. Motivation waslow. He was given intensive, individualized remedial training for 6 months to improve academic skills. Guidance was given to improve his motivation. Academic skills improved significantly after 6 months. Now, he is studying well and is very much interested to go to school.

Learning Disorders

Children with learning disorders have difficulties in acquiring academic skills. They have difficulty in reading, difficulty in understanding the meaning of what is read, errors in spelling, errors in grammar, difficulty in mastering number facts or difficulties in mathematical reasoning. Academic skills are substantially below those expected for the age and significantly interfere with academic performance. Learning disorder can be mild, moderate or severe. About 10 to 20% of school going children have learning disorders. Their intelligence will be average or above average. Usually children with learning disorders are brought to child guidance clinic due to various reasons like failure in examinations, significant reading difficulty, not writing down notes in class, forgetfulness, not concentrating in studies, reluctance to go to school, lowself-esteemand anxiety related to exams.

Learning disorder with impairment in reading

The features include:Poor reading fluency, slow reading speed, inadequate comprehension, poor spelling skill, impairment in properly sequencing words, mirror reading(reversal of words or letters), inability to recall facts that have been read and difficulty in drawing conclusions or inferences from the material that has been read.

Learning disorder with impairment in writing

Some of the common features of disorder of written expression include:Poor handwriting, poor paragraph organisation, large number of grammatical errors spelling errors, punctuation errors, reluctance to do assigned written homework and mirror writing.

Learning disorder with impairment in mathematics

Children with mathematics disorder have significant difficulty in acquiring basic mathematical skills like addition, subtraction, multiplication and division. They can also have impairment in linguistic skills related to understanding mathematicalterms as well as difficulty to recognise and understand symbols.

Management

In children with scholastic backwardness, assessment of intelligence is essential to rule out intellectual disability. If intelligence is normal, a detailed assessment of academic skills should be done to find out the reason of poor academic performance. Learning disordershould be managed through intensive, individualized, one on one remedial training. Good therapist-child relationship is essential. Associated behavioural and emotional problems if any, should also be identified.Behavioural and emotional problems should be managed through behaviour therapy and cognitive therapy. Motivational counselling and study skills training also haveimportant role inmanagement. Parental guidance is necessary in managing the learning problems of children.

For Attention of Parents

If the child has scholastic backwardness or reluctance to go to school,find out the exact reason with the help of an expert in child guidance.Learning disorders should be identified at the earliest and managed scientifically. Motivate the children to improve their talents and academic skills.Unnecessary criticisms and comparison should be avoided.Be empathetic with children and maintain a very good interpersonal relationship with them.

Conclusion

Scholastic backwardness is common among school going children and adolescents. If learning problems of children and adolescents are not managed properly, it will lead to significant stress. Hence any individual with difficulty in reading, writing or arithmetic skills and deterioration in academic performance should be managed scientifically at the earliest. Victory over learning disorder is possible through early diagnosis and intensive, individualised remedial education program.

What mothers should know about Menstruation

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Rinu was in tears when she returned home early from school. When her mother asked her what had happened, she sobbed, “I’ve got Cancer!” It turned out that she had noted blood on her underwear. She had just attained menarche. Though her mother was relieved and explained that this is a benign occurrence, Rinu was quite upset about the incident. Her mother’s meager explanation did not help: she just told her daughter that this is a nuisance that happens to every woman after a certain age, and then she taught her how to use a sanitary cloth.

Mothers should inform their daughters about menarche before it happens!

Every mother knows this, but many mothers do not do it, because they do not know what to tell their young daughters, and they are scared that if they say the wrong thing they may end up doing more harm than good. That is exactly what happened in Rinu’s case. So let us see whether there is a better way of explaining the matter.

What to tell your daughter before she has menarche

“Today you are still a child, though you have started growing tall. But one day a very special incident will happen. You will notice a little painless bleeding from the area where you pass urine. That is known as Menstruation. ***From that day onwards you will no longer be a child, but an Adult!*** This happened to me when I was about your age. It happens to every woman at about this age. It is a proud event in a woman’s life. Once it starts it happens every month for the

next 30-40 years. Did you see that advertisement for a sanitary pad on TV? We women use the pads inside our underwear on the days that we are having menstruation, so that our underwear and clothes do not get wet."

When to tell her this?

Menarche usually occurs anywhere between 10 and 16 years of age. Most girls experience it at around 12-13 years today, whereas their mothers experienced it a little later, at around 13-14 years. If the mother and her sisters experienced menarche later than their friends, then the girl will also usually experience menarche a little later than her friends.

So when should a mother talk to her daughter about menarche? Probably all girls should be told about it before they reach their 12th birthday. Even if they are not going to have menarche till two years later, their classmates will attain menarche, and will talk about it, and much of the talk will be confused and frightened and wrong. It is better that your daughter knows the truth early enough.

Menarche can occur before this. If the girl is rapidly growing tall, and her breasts start developing, do not wait till her 12th birthday, but talk to her about it at once. Girls who are well-nourished or obese tend to attain menarche earlier.

What to tell your daughter when she attains menarche:

Congratulate her! Not only the mother but all female relatives should praise her.

If a girl attains menarche very early she needs reassurance because she has never heard her friends talking about it, and she may be scared. There is a very bad tendency among mothers and aunts to express sympathy for the girl's "suffering" when menarche occurs early: this only causes a lot of mental agony to the child. The mother should warn the aunts and female neighbours and

grandmothers not to talk in this manner, but rather to congratulate the girl for becoming an adult.

After this one should discuss menstruation with her in more detail. A mother who feels too embarrassed to do so should make it her duty to find an aunt or loving neighbour to do this. Or she can give her daughter the following matter to read:

(*The following matter should preferably be in a page that the mother can tear out and give her daughter to read. There should be a picture too*)

Why does menstruation occur?

(Pic) This is the Female Reproductive System. The main parts are the uterus, the ovaries, and the fallopian tubes. From the outside of the body there is a passage called the vagina, which reaches up to the uterus. Once a month the ovary sends an ovum (egg) to the uterus, and the uterus makes a special inner lining within itself to receive the ovum. After some weeks the ovum and inner lining of the uterus are discarded. They are excreted through the vagina, along with a little blood, and this is known as menstruation. It usually occurs once a month, for 3-5 days, with mild abdominal pain on the first day. There is often mild body pain for a few days.

Can a girl go to school if she has menstruation?

Certainly! Menstruation is a normal and healthy phenomenon. You should go to school, you can run around and play games, you can work in the kitchen – you need not restrict yourself in any way.

Is Menstruation painful?

Some girls have a lot of pain on the first day, which may even make them faint or prevent them from going to school. But there is no need to suffer like that. If you have pain, you should just take a painkiller. For example, Brufen-400. You

can take up to three tablets in a day, after food. Then you can go to school. You will not need tablets on the second day. The tablets only reduce the pain, they do not reduce or increase the menstruation. There is no need to consult a Doctor about this. Some persons get stomach pain when they take this tablet, especially if they take it before food. If so, take half the dose.

Can a girl bathe on these days?

It is very important to be clean during menstruation. You should bathe every day during this time, and preferably twice a day. You should change your sanitary pad or cloth after the bath, and as frequently as needed, depending on the amount of blood loss.

Do boys have anything equivalent to menstruation?

Of course! We mentioned that menstruation is due to the excretion of the spoiled ovum and inner lining of the uterus. Well, in boys the testes produce a lot of sperms, and these too will be excreted after some weeks. One morning the boy wakes up and finds that his underwear is sticky. This is because the sperm were sent out of the body when he was fast asleep. This is known as “nocturnal emissions”. It occurs very irregularly.

Let us now discuss some aspects of menstruation that mothers would like to know.

Menarche too early

Menarche occurs earlier today than in the past, usually at around 12-13 years of age. If it occurs before 10 years, it is better to consult a Doctor. Usually it will be normal, but rarely a very early menarche may be due to some hormonal problem.

Menarche too late

If a girl has not attained menarche by 16 years of age, she should always consult a Doctor. Even a 14 years old girl who has not attained menarche should see a Doctor if she is not growing tall and breasts are not enlarged. The commonest cause of a mild delay is familial i.e. if her mother and sisters attain menarche at 15 years, the girl also will usually attain menarche by about 15 years. But there are other causes too, which may need treatment.

Very infrequent menstruation

In the first two years menstruation is often very infrequent and scanty, because the reproductive system needs time to become mature. After that it should be regular.

We say that menstruation occurs every month because it usually occurs every 28-30 days. But this varies from once in 20 days to once in 45 days for perfectly healthy women. So even if it occurs only once in 45 days it is OK, so long as it is somewhat regular. If menstruation is both infrequent and scanty, it is better to consult a Doctor.

Frequent or Heavy Bleeding

The mother should show her daughter to a Doctor if menstruation occurs too frequently (more than once every three weeks) or if she feels that the girl's bleeding is too heavy, or if there are blood clots, or if the bleeding makes the girl tired and pale.

Anaemia

As it is, anaemia is very common. On top of that menstruation makes a girl lose blood. If a girl has anaemia, she should see a Doctor and then take iron tablets for as long as is necessary. But even if a girl does not have anaemia, it is a good

idea to give every menstruating girl one iron tablet every week. The iron tablets available in Government hospitals are as effective as the costly tablets available in the market.

Vaginal discharge

Many girls have a little clear discharge from the vagina at times, which increases just before menstruation. This is normal. But if the discharge is large in quantity, or yellow in colour, or bloody, or it has a foul smell, or it causes a burning sensation on passing urine, or severe itching locally, then it is caused by an infection, and needs to be treated.

Conclusion

Mothers should never pretend to themselves that their daughters are “too young to know these things”. The girl will get information about these matters from her classmates, and usually the information will be wrong and scary. It is preferable that she learns the truth from a reliable person – her mother.

Adolescent Gynaecological Issues

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Adolescence is a period of significant physical, cognitive, and psychosocial growth and development in the life of an individual. The gynaecologic problems seen in adolescents are unique to these age groups and may involve physician skills differing from those utilized for adults for management. Health care in the adolescent female should include a review of normal menstruation, diet and exercise, healthy sexual decision-making, relationships and immunizations. Preventive counselling is beneficial for them and their parents and can include discussions about physical, sexual, and emotional development, signs and symptoms of common conditions affecting adolescents and encouragement of lifelong health choice behaviour. Though challenging, yet despite their stereotypical outward appearance of shunning and ignoring authority figures, when medical providers are able to create a safe, confidential, non-judgmental, and empowering atmosphere, adolescents are surprisingly open and candid about themselves, their health, and their behaviour, including sexuality.

The common health problems an adolescent can present with are dysmenorrhea, amenorrhoea, vulvar diseases, pelvic masses, Mullerian developmental anomalies, pelvic pain among others

Disorders of sex development (DSDs) are infrequent medical conditions in which the development of chromosomal, gonadal, or anatomic sex and is a challenging presentation to diagnose and manage because of the complexities involved. The management of these patients require a thoughtful contemplative health care provider and must address medical, surgical, and psychosexual needs ofthe individual patient. Similar the diagnosis and management of Mullerian anomalies requires not only knowledge of embryologic development, but an awareness of the known associations of structural anomalies of the female reproductive tract with other congenital anomalies, including renal anomalies and anorectal malformations. An organized discussion is advantageous for appropriate diagnosis, management, and possible referral. Familiarity with the anomalies, associations and optimal treatment helps provide the recommended clinical care in a timely way, avoiding unnecessary delays and potential compromise to reproductive success.

Genital injuries may occur accidentally or as the result of an act of violence. Awareness needs to be heightened among individual providers of medicalcare to protect young girls from becoming victims of violence of sexual or nonsexual nature and to provide avenues for recovery.

Among adolescents, rate of physical development surpasses their rate of cognitive development. Adolescentsare physically able to engage in behaviours that place them at risk for STIs, but they have not yet fully developed the capabilities to judge when and how to protect themselves. Gynaecologists are in the unique position and are a potentially valuable resource to educate adolescents about their health and their bodies in a private and safe environment where they can offer individualized information and strategies

toguide adolescents and young adults toward physical and emotional health. The future of adolescent contraception requires the collaboration between providers,patients, and, sometimes, their parents. New contraceptive methods allow teens to choose from a variety of convenient, safe, reliable, and confidential options. The ability to provide non-discriminatory, confidential,accessible care and our role in the education and guidance arelikely to determine the future of this generation of teens.Long-term contraceptives, such as injectables and implantable devices or IUDs, are safe for use in young patients. As providers of adolescent health care, encouraging patients and other providers to use these methods should be part of our efforts toimprove the health care of this population.Emergency contraception (ECP), the use of nonabortifacient hormonal medicationswithin 72 to 120 hours after unprotected or under protected coitus for the preventionof unintended pregnancy, is an important part of contraception counselling in adolescents.

Polycystic ovary syndrome (PCOS) is a heterogeneous endocrinologic disorder that is characterized by oligo- or amenorrhea and signs of hyperandrogenism and is being commonly seen in adolescents. The cause of PCOS is unknown, but the syndrome is associated with insulin resistance, which, in turn, leads to hyperandrogenism.Long-term health consequences of PCOS are significant and include obesity, diabetes, metabolic syndrome and anovulatory infertility. The symptoms of PCOS can be disturbing to an adolescent girl. Early diagnosis and intervention are important to treat these symptoms and prevent long-term sequelae. Current treatment regimens target the specific symptoms of PCOS. These include weight management and reduction programs for obese adolescents and hormonal contraceptives and antiandrogensfor menstrual

irregularity, hirsutism, and acne. Insulin-sensitizing agents are also used in the treatment of this disorder, especially in those with insulin resistance.

The presence of endometrial glands and stroma outside the uterus, typically in the pelvis, is known as endometriosis. An adolescent with this diagnosis usually presents with chronic pelvic pain. Traditionally, endometriosis had been thought to occur only rarely in adolescence, but with an increasing awareness of the disease it is being diagnosed more frequently. The natural history of endometriosis remains largely unknown; therefore, it is difficult to determine whether early intervention in adolescents enhances future fertility or improves long-term disease outcome. The most immediate issue is a young woman in pain and a physician who needs to make a diagnosis and manage the symptoms. Laparoscopy remains the gold standard for establishing the diagnosis, and long-term control of symptoms in adolescents requires medical management, often in combinationwith complimentary therapies.

Adolescents who bleeding disorders come to the attention of the gynaecologist when menarche is anticipated and they develop abnormal uterine bleeding. Menorrhagia is the most common symptom that adolescents who have bleeding disorders experience. Not only is menorrhagia more prevalent among adolescents who have bleeding disorders, but bleeding disorders are more prevalent among adolescents who have menorrhagia. Adolescents who have bleeding disorders are probably also at an increased risk for haemorrhagic ovarian cysts and endometriosis. The patient who is suspected of having a bleeding disorder is referred to a haematologistor physician for diagnosis Adolescents and their parents need to understand and accept that hormonal contraception is the first-line treatment for

menorrhagia. Successful management of bleeding in adolescents requires the combined expertise of knowledgeable haematologists and gynaecologists

The diagnosis and management of ovarian masses in adolescents is a very challenging problem faced by gynaecologists. Ovarian masses in adolescents are uncommon and have diverse presentations ranging from asymptomatic masses to acute abdominal pain. Benign and functional cysts are the most common ovarian lesions in adolescence. Although majority of the lesions are benign, it is important to identify notoriously lethal malignant lesions early for favourable prognosis. The conflict between surgical vs. conservative management in adolescent ovarian masses is challenging for the gynaecologist. The risk of malignant neoplasms is lower among adolescents than among younger children. Early correct diagnoses and preservation of fertility should be the aim. Support and sensitivity for the frightened girl and her family is essential as is high quality decision making by the gynaecologist.

The gynaecological problems encountered in adolescents are often both medically and psychologically complex and thus require a highly skilled and coherent approach. The adolescent, who is no longer a child but not quite an adult, poses a particular management problem to the traditional specialties. Education, counselling and preventive services are all needed to improve the overall health condition of the adolescents who form a major part of our population.


THANK
YOU!