



Where Children Come First



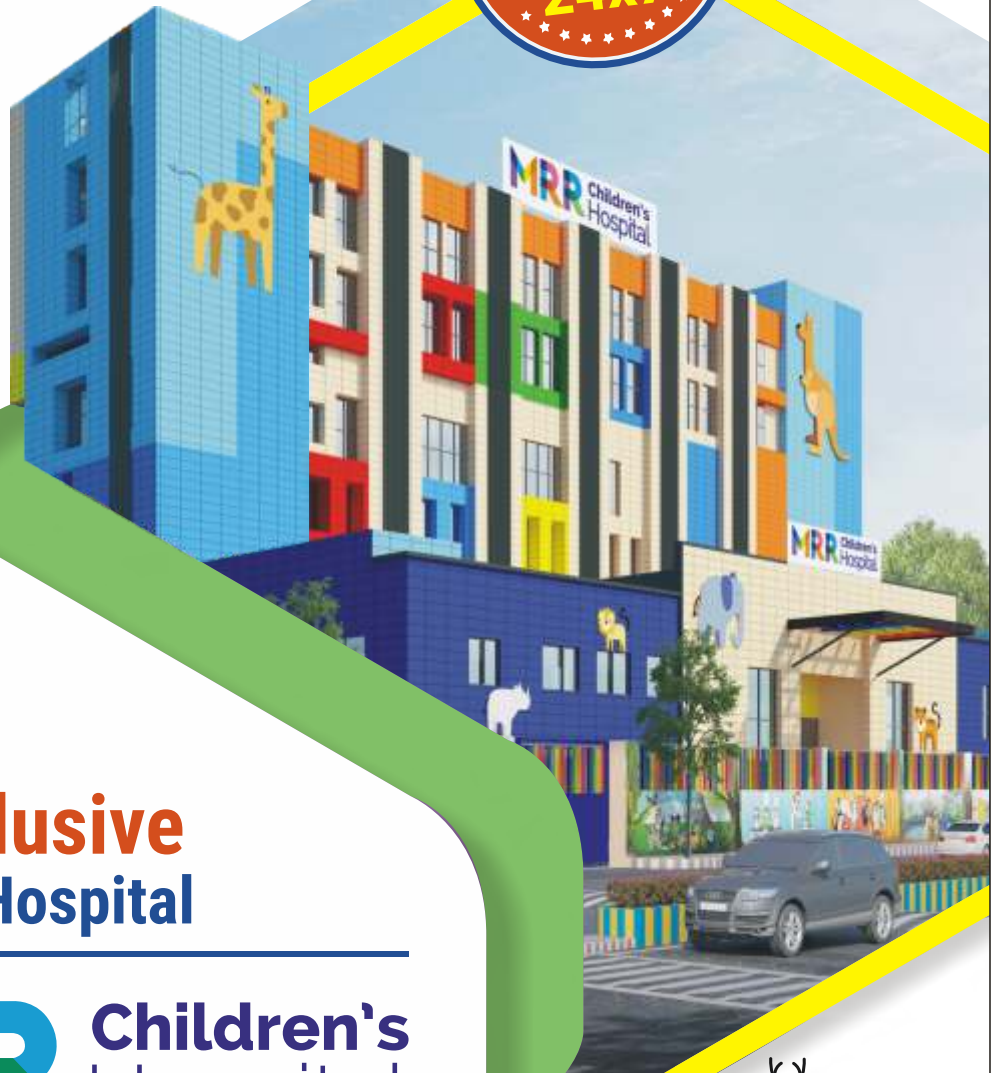
ADVANCES IN PAEDIATRICS

THE MONTHLY NEWSLETTER

2024 DECEMBER

11TH ISSUE

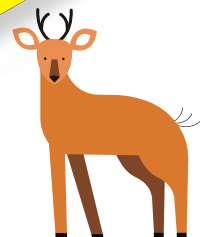
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Thane's First Exclusive Children's Hospital

MRR Children's
Hospital

WHERE CHILDREN COME FIRST



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ADVANCES IN PAEDIATRICS

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Dr Sandeep M. Kelkar
(Editor-In-Chief)

Dr Kiran More
Dr Praveen Gokhale

Editor's Thoughts

Dear Friends and Colleagues,

Festive Greetings To All!

Welcome to the December edition of "**Advances in Paediatrics**," where we focus on themes that are not only crucial to our clinical practices but also resonate with the broader spectrum of paediatric care.

In the month of December, we reflect on the profound words of renowned child psychologist **Dr. Maria Montessori**: "**The child is both a hope and a promise for mankind**". As we embrace the spirit of the season, we reaffirm our dedication to fostering the health and well-being of children everywhere.

December is a month rich with observances dedicated to child health. We hereby acknowledge **World Prematurity Day** (November 17) and **International Day For The Rights Of The Child** (November 20), both of which remind us of the urgent need for advocacy and action in our pursuit of better health outcomes for children on a global scale. In our **FEATURED ARTICLE**, "**Bladder Dysfunction Disorders In Children – Key Tools In Management**," the article emphasises critical innovations in diagnosis and management that underscore our commitment to evidence-based practices in paediatrics.

In this month's **BREAKING NEWS** section, we present timely insights into groundbreaking advancements in the field of **Pathology**. Staying abreast of these developments is essential for enhancing clinical decision-making and improving patient care. To enhance your clinical practice, we unveil a practical **DECISION-MAKING TREE** designed for the evaluation of '**Nephrotic Syndrome In Children**'. This resource serves to systematically aid clinicians in their assessment and management of nephrotic syndrome. Our "**PAST CURIOUS-THE SAGAS OF HISTORY OF MODERN MEDICINE**" segment offers a captivating journey into the history of modern medicine. This issue talks about the evolution of titles like doctor, surgeon and physician, highlighting a holistic understanding of health—each title encapsulating distinct yet interconnected layers of our rich medical heritage.

In our **SUBSPECIALITY SPOTLIGHT** segment, we shine a light on "**Drowning In Children**." This section showcases current best practices aimed at fostering enhanced outcomes.

In our **SAMPOORNA SWASTHYA SANWARDHAN (संपूर्ण स्वास्थ्य संवर्धन)** section, we address the importance of "**Cultivating Emotional Vocabulary In Children For Raising An Emotionally Intelligent Child**." This article not only provokes thought but also offers practical strategies to better equip parents and educators in enhancing Emotional Intelligence (EQ) among children, laying a foundation for their future well-being.

As we approach the end of the year, let us draw inspiration from Dr. Montessori's wisdom. Together, we have the power to nurture hope and promise for the children in our care. May this season of reflection and celebration renew our resolve to advance the health and well-being of children everywhere.

Warm regards,

Dr Sandeep M Kelkar MD Dch

Editor-in-Chief &

Director-Department of Paediatrics





Featured Article

Bladder Dysfunction Disorders In Children - The Key Tools For Management

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Bladder dysfunction disorders in children, such as frequency, polyuria, enuresis, incontinence, neurogenic bladder and urinary tract infections, can significantly impact quality of life and development. Effective management relies on targeted history, specialised tools and approaches, from diagnostic imaging and urodynamics to non-invasive monitoring devices and therapeutic strategies, ensuring tailored, child-centred care for better bladder health. However, before specialised investigations are done, a targeted history and directed investigations must be carried out to decide further course of action.

Following are the practical tips to evaluate these children.

A. History

1. Bladder Bowel Dysfunction: Ask patients the following questions:

- Is the child toilet trained?
- Does he regularly pass soft-formed stools on a daily basis?
- Does he use Indian commode/Western commode/Western commode in 'Indian style' (*squatting while using the Western commode*)?
- While using a Western commode do their feet comfortably reach the floor or do they use a step/stool to support their feet?
- Use objective stools like '**Bristol Stool Form Chart**' to show parents and ask them the stool type.

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clean-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid

What is normal on the Bristol Stool Chart?

- Type 1-2 indicate constipation
- Type 3-4 are ideal stools as they are easier to pass
- Type 5-7 may indicate diarrhoea and urgency

1. Bladder Diary

- Ask all polyuria/increased frequency children, who are toilet trained to do a 24-hour intake output charting of fluid intake and urine volume voided.
- Ask for the presence of lower urinary tract symptoms: frequency/urgency/hesitancy/painful micturition/poor urinary stream/incontinence or dribbling.



B. Clinical Examination (Specific Signs)

- a. Cutaneous markers of spinal dysraphism
- b. Lower limb neurological examination
- c. Palpable bladder (before and even after voiding)
- d. Faecal loading
- e. Perineal examination (genitals, anal tone)
- f. Look at the underwear to look for soakage with urine or stool
- g. Observation of urinary stream

C. Red Flag in Bladder Issues

- a. **Secondary** nocturnal enuresis (after a 6-month “dry” period)
- b. **Weak urine flow, intermittent miction, straining to void**— *anatomical and neurological causes should be excluded*
- c. **Systemic symptoms** such as weight loss, nausea, excessive thirst—chronic kidney disease and diabetes (both mellitus and insipidus) should be excluded
- d. **Skin changes** in the lumbar region, sensory disturbances in the perineum
- e. **Lab value derangements** like low specific gravity, glucosuria, proteinuria, leukocyturia, haematuria, raised creatinine

D. Requesting Appropriate Ultrasound

Whenever we request an ultrasound for a child with bladder issues, always communicate with the sonologist regarding the clinical diagnosis of the child. In case of an unknown centre, please ensure that the following points are requested in the report:

- a. Kidney sizes in cm/mm
- b. AP diameter of the renal pelvis if hydronephrosis +
- c. Visibility of ureters
- d. Bladder wall thickness
- e. Pre and post void volume (** Also, verbally tell the parents/patient that **sonography needs to be done twice: once after drinking water when the child gets a sensation to pass urine and later, once they have passed urine**).

E. Interpretation of the Renal Ultrasound Report

- a. Kidney sizes: The radiologist will inform us if the renal sizes are age-appropriate or not.
- b. Echogenicity of kidneys: This is always reported in comparison to the echogenicity of the liver. Echogenic kidneys always need evaluation. Echogenic kidneys suggest altered renal function.
- c. Anteroposterior diameter (APD) of the renal pelvis: Most centres report hydronephrosis as 'mild', 'moderate' or 'severe'. Please request the sonologist to give you measurements of the APD. This is helpful for serial follow-up of the patient and provides objectivity if different radiologists do follow-up scans at different centres.
- d. Bladder Volume
 - i. The expected bladder capacity (EBC) is calculated using the formula **EBC (ml) = (Age in years +1) x 30**
 - ii. Bladder capacity < **65%** (small void) or > **150%** (large void) of the expected bladder capacity is **abnormal**

Successful evaluation of a bladder complaint requires a watchful paediatrician (as the lead investigator) - always, clinically oriented radiologist - always and paediatric nephrologist along with paediatric urologist - sometimes.



BREAKING NEWS

IN PAEDIATRICS

Here we share the latest practice-changing updates in the field of paediatrics



Microfluidic Device Applications In Diagnosis And Research

Dr Tejas Kulkarni

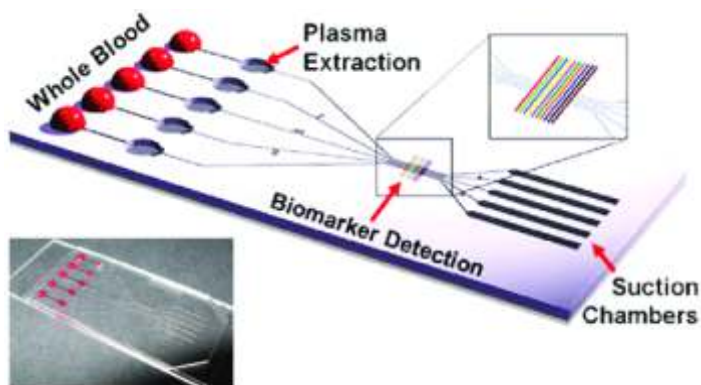
Consultant Pathologist
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Microfluidic devices exploit the physical and chemical properties of liquids and gases at a microscale. Microfluidic devices offer several benefits over conventionally sized systems. Microfluidics allow the analysis and use of less volume of samples and reagents reducing the global fees of applications. Many operations can be executed immediately thanks to their compact size, shortening the time of diagnosis.

Today, microfluidics provide efficient tools for multiple research areas and more specifically for biological analysis:

1. Whole biological process integrated and simplified for the end users
2. High-throughput, multiplexed and highly parallelised assays
3. Faster analyses due to the shorter reactions and/or separation times
4. Portable devices for point-of-care applications
5. Low reagent consumption
6. Global cost reduction per analysis
7. Accurate measurement, microfluidics allowing to increase the measurement resolution in given applications

Microfluidics in Diagnosis: A lab-on-a-chip (LOC) is a device performing on a miniaturised scale one or several analyses commonly carried out in a laboratory. It integrates and automates multiple high-resolution laboratory techniques such as synthesis and analysis of chemicals or fluid testing into a system that fits on a chip. There are many advantages to operating at this scale. Samples analysis can occur on location, where the samples are generated, rather than being carried to an extensive laboratory facility. Fluids' behaviour at this scale makes it easier to control the movement and interaction of samples, causing reactions to be much more potent and minimising chemical waste. It also reduces exposure to dangerous chemicals.



Example of a compact, stand-alone Lab-on-a-chip (LOC) device



Microfluidics in Research:

Organs on chips are 3D cell culture microdevices aiming to reproduce the key functions of living organs on a computer chip. These microfluidic devices are more efficient than conventional cell culture techniques since they are able to mimic microenvironments as well as their influence on organ function. This allows to research on the human physiology for a specific organ and initiate advancements in artificial disease models. Organs on chips use microfluidics and microfabrication technologies to better replicate the functionalities of living organs. Among them, we can find models like gut on a chip, heart on a chip, liver on a chip, lung on a chip, tumour on a chip, muscle on a chip, multiple organs on a chip, etc.

Microfluidic Device Applications in a Paediatric Setting:

1. Analysis of various analytes in the emergency setting, especially in neonates where the sample volume is low
2. As part of a bedside newborn screening programme for high-risk screening
3. Microfluidic technology can also be used to precisely control the release of drugs in a time-regulated manner

References:

1. Nguyen, N.-T., & Wereley, S. T. (2006). "Fundamentals and Applications of Microfluidics." Artech House.
2. Weibel, D. B., & Whitesides, G. M. (2006). "Applications of microfluidics in chemical biology." *Current Opinion in Chemical Biology*, 10(6), 584-591.
3. Beebe, D. J., Mensing, G. A., & Walker, G. M. (2002). "Physics and applications of microfluidics in biology." *Annual Review of Biomedical Engineering*, 4, 261-286.
4. Thorsen, T., Maerkl, S. J., & Quake, S. R. (2002). "Microfluidic large-scale integration." *Science*, 298(5593), 580-584.



DECISION-MAKING TREE

Algorithm for the evaluation of 'Nephrotic Syndrome In Children'

Evaluation of infants and children with nephrotic syndrome

Child with Both of the Following:

- **Nephrotic range proteinuria**
 - More than 50 mg/kg protein in a 24-hour urine collection OR
 - Early morning urine protein to creatinine ratio >2 mg/mg (>200 mg/mmol).
- **Hypoalbuminemia**
Serum albumin level <3 g/dL (<30 g/L).

Additional Evaluation Includes:

- Focused history and examination to identify potential causes or complications.*
- Urinalysis with microscopy.
- Serum electrolytes.
- BUN and creatinine.
- Lipid panel.
- Complement levels.

Are Any of the Following Present?

- Age <3 months at onset.
Extra-renal features suggestive of a congenital syndrome.[†]
- Family history of nephrotic syndrome or other kidney diseases.

Yes

NO

Congenital/Nephrotic Syndrome is Likely.
• Refer for genetic testing.

Are Any of the Following Present:
• Hypertension.
• Gross hematuria.
• Elevated serum creatinine.
• Low serum complement levels.
• Extra-renal symptoms suggestive of a secondary cause.[‡]

Yes

NO

Causes Other Than MCD Are Likely.*
• Perform a kidney biopsy to make a histological diagnosis.
• Additional evaluation may include testing for specific diseases, depending on the presentation.*

What is the Age at Onset?

3 Months to 1 Year

1 to 12 Years

>12 Years

Genetic causes, MCD, and other causes are all possible.
Options include:
• Trial of glucocorticoids.
• Refer for genetic testing.
• Perform kidney biopsy.

MCD is the Most Likely Cause.
• Trial a course of glucocorticoids.
• Response supports the diagnosis of MCD.[§]

Causes Other Than MCD Are Likely.¶
• Offer kidney biopsy to make a histological diagnosis.
• A trial course of glucocorticoids is a reasonable alternative.

BUN: blood urea nitrogen; GN: glomerulonephritis; HIV: human immunodeficiency virus; MCD: minimal change disease; NS: nephrotic syndrome; SLE: systemic lupus erythematosus.

* Potential complications include: hypertension, hematuria, hypovolemia, or rare complications such as bacterial or viral infection, thromboembolism, or pancreatitis.

† These include dysmorphic features, ambiguous genitalia, eye abnormalities, and developmental delays.

‡ Extra-renal symptoms suggestive of a secondary cause of NS include: malar rash, adenopathy, purpura, recent group A streptococcal infection of the skin or throat.

§ Other causes include: SLE, chronic hepatitis B or C, HIV, postinfectious GN, vasculitis, or genetic causes.

¶ This could include testing for SLE, vasculitides, or infectious agents. Refer to other UpToDate content for details.

× We use shared decision-making with parents to individualize the choice among these options. However, some other experts proceed to genetic testing for all children in this age group given that it is widely available and easy to perform.

† For those who do not respond, additional workup may include genetic testing or kidney biopsy. Refer to other UpToDate content on steroid-resistant nephrotic syndrome in children.



SUBSPECIALITY SPOTLIGHT

In this section, we focus on a short article on one Paediatric Subspeciality.
This time it will be on Drowning In Children

Drowning In Children

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Introduction:

Drowning is the second most frequent cause of unintentional injury death among children in the United States, following traffic accidents. But Indian studies say it's the least common cause of accidental injury in children. The World Congress on Drowning and the World Health Organization (WHO) definition of drowning is "the process of experiencing respiratory impairment from submersion/immersion in liquid." The risk of drowning and the circumstances leading to it vary by age and other host factors like gender, alcohol/drug use, history of seizure, cardiac arrhythmia and swimming lessons.

In children <1 year, the majority of drowning deaths (75%) occur in the bathtub, whereas in children between the ages 1-4 years, most commonly drowning occurs in a swimming pool because of their curious nature. School-age children are at increased risk of drowning in natural bodies of water like lakes, ponds and rivers.

Pathophysiology:

Drowning victims drown quickly and quietly and do not signal distress or call for help. Young children can struggle for only 10-20 seconds and adolescents for 30-60 seconds before final submersion. The instinctive drowning response is a phenomenon where actual or perceived suffocation in water triggers autonomic nervous system responses, resulting in unlearned, instinctive drowning movements.

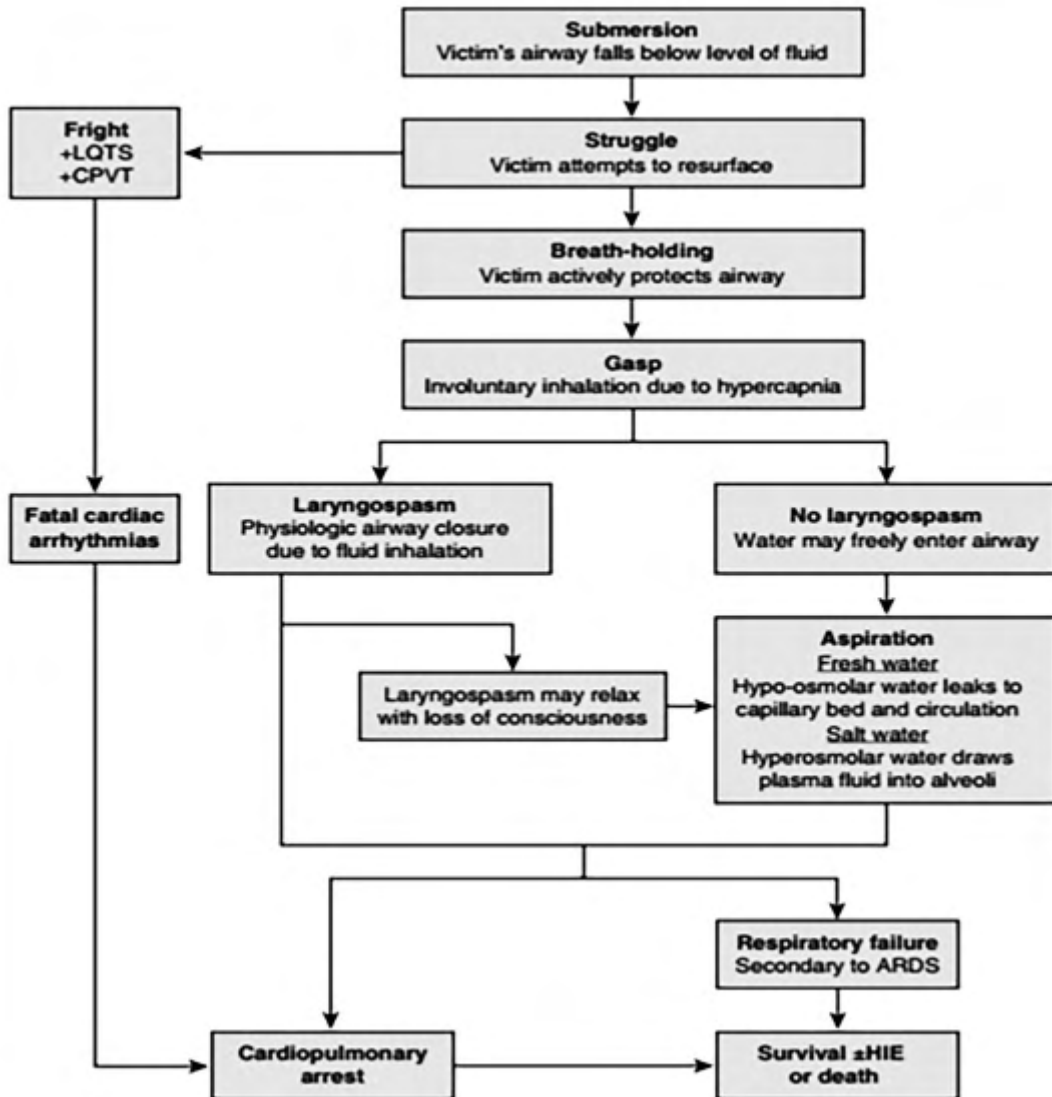


Fig.1. Pathophysiologic events of the drowning process. LQTS- Long QT syndrome, CPVT- Catecholaminergic polymorphic ventricular tachycardia. (Chapter 88, Drowning and submersion injury, Nelson's textbook of Pediatrics, Ed 22)

Management:

The duration of submersion, speed of the rescuer, effectiveness of resuscitative efforts and clinical course determine the outcome of submersion victims (Fig 2).

Initial Management:

The goal is to reverse the anoxia from submersion and limit secondary hypoxic injury after submersion, which depends on immediate resuscitation at the submersion site, even before the arrival of emergency medical service (EMS) personnel.



Initial resuscitation must focus on rapidly restoring oxygenation, ventilation and adequate circulation. The airway should be clear of vomitus and foreign material, which may cause obstruction or aspiration. Abdominal thrusts should not be used for fluid removal because

many victims have a distended abdomen from swallowing water; abdominal thrusts may increase the risk of regurgitation and aspiration. The Cervical spine (C-spine) should be protected in anyone with potential traumatic neck injury. If the victim has ineffective respirations or apnea, ventilatory support must be initiated immediately. The child's cardiovascular status must be evaluated and treated according to the usual resuscitation guidelines and protocols.

Recognition and treatment of hypothermia are unique aspects of cardiac resuscitation in the drowning victim. Moderate to severe hypothermia can depress myocardial function and cause arrhythmias. Wet clothing should be removed to prevent ongoing heat losses. Rewarming should be initiated in the controlled environment of the receiving ED or PICU.

Hospital-based evaluation and management

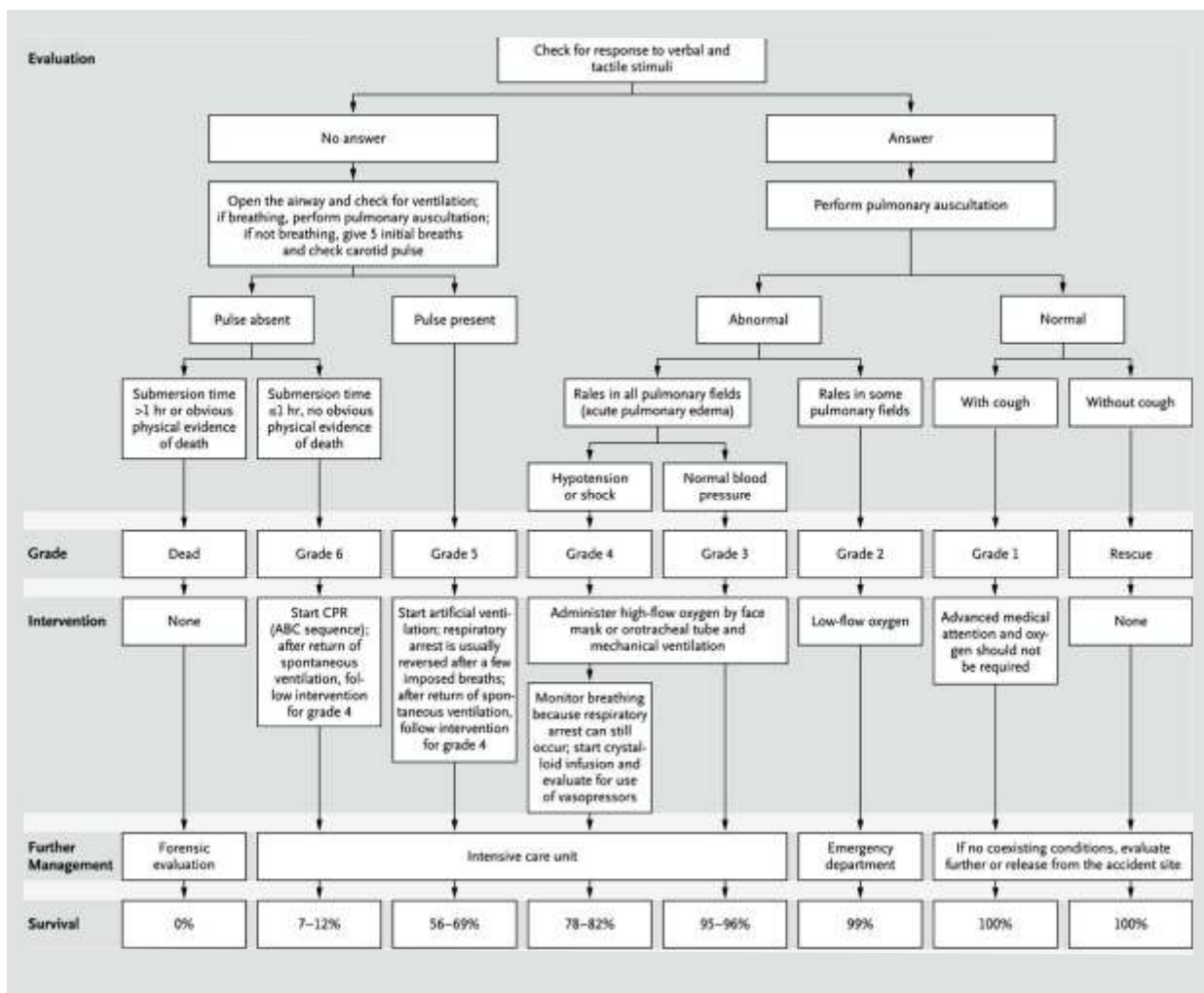


Fig.2. Treatment of persons who have drowned, with classification system. (From Szpilman D, Bierens J, Handley A, Orloweski J. Drowning. N Engl J Med 2012;366:2102–2110.)



Additional Management Issues:

1. Hypothermia management: The goal is to prevent moderate to severe hypothermia. A damp cloth should be removed. Rewarming measures are generally categorised as passive, active external or active internal.
2. CPR recommendation for drowning victims:

When to initiate	Initiate ventilation in persons with respiratory distress or respiratory arrest to prevent cardiac arrest Initiate CPR in persons who have been submerged for <60 minutes and who do not have obvious physical evidence of death (rigor mortis, body decomposition or livor mortis)
When to discontinue	Continue basic life support unless signs of life reappear, rescuers are exhausted or advanced-life-support team takes over Continue advanced life support until the patient has been rewarmed (if hypothermic) and asystole has persisted for >20 minutes

3. Traumatic injury: Many drowning victims may have traumatic injuries, especially if their drowning event involved participation in high-energy water sports like boating, diving or surfing. A high index of suspicion for such injury is required.

Prognosis:

Important Facts and Predictors of Outcome in Resuscitation of a Person Who Has Drowned
• Early basic life support and advanced life support improve outcome • During drowning, a reduction of brain temperature by 10°C decreases ATP consumption by approximately 50%, doubling the duration of time that the brain can survive • Duration of submersion and risk of death or severe neurologic impairment after hospital discharge ○ 0–5 minutes – 10% ○ 6–10 minutes – 56% ○ 11–25 minutes – 88% ○ >25 minutes – nearly 100% • Signs of brain-stem injury predict death or severe neurologic sequelae • Prognostic factors are important in the counselling of family members and are crucial in informing decisions regarding more aggressive cerebral resuscitation therapies

Prevention:

The most effective way to decrease the injury burden of drowning is prevention. Drowning is a multifaceted problem, but several evidence-based preventive strategies are effective. The paediatrician has a prime opportunity to identify and inform families at risk of these strategies through anticipatory guidance.



Approach to Prevention Strategies for Drowning			
	Home	Recreation	Neighbourhood
Water hazards	- Swimming pools - Ponds - Bathtubs - Large buckets - Drain entrapment	- Playing in water (swimming, wading) - Playing near water - Being on water (boating)	- Irrigation ditches - Watering holes - Water drainage
Common risks	- Lapse in supervision - Unexpected toddler exposure - Delayed discovery of child - Reliance on water wings or pool toys - Reliance on sibling or bath seat for bathing supervision - Epilepsy - Autism - ADHD - LQTS	- Lapse in supervision - Change in weather - Unfamiliarity with or change(s) in water conditions: - Steep drop-off - Current/tide - Low temperature - Alcohol and other drug use - Peer pressure	- Lapse in supervision, particularly when the caregiver is socialising - Risky behaviour when with peers
Prevention strategies	- Recognise hazards and risks - Provide constant adult supervision around water - Install 4-sided, isolation locked fencing of pools - Install rescue equipment and phone at poolside - Learn swimming and water survival skills - Avoid unsupervised baths in older child/teen with seizure disorder; instead, shower - Learn first aid and CPR	- Provide constant adult supervision - Swim in lifeguarded areas - Avoid alcohol and other drugs - Learn swimming and water survival skills - Teach children about water safety - Be aware of current weather and water conditions - Buddy system - Learn first aid and CPR	- Identify hazardous bodies of water - Prevent access to water with barriers - Provide fenced-in "safe area" for water recreation - Provide lifeguarded swim sites - Provide access to low-cost swim/water survival lessons

References:

1. Drowning. N Engl J Med 2012;366:2102–2110
2. Chapter 88, Nelson Textbook of Pediatrics, 22nd Ed.
3. Nooyi SC, Sonaliya KN, Dhingra B, Roy RN, Indumathy P, Soni RK, et al. Descriptive epidemiology of unintentional childhood injuries in India: an ICMR taskforce multisite study. Indian Pediatr. 2021;58(6):517–24



PAST CURIOUS: THE SAGAS OF HISTORY OF MODERN MEDICINE

Here we share a short informative article on the study and evolution of medical treatments, practices and knowledge over time



Doctor vs Surgeon: What is in a title?

The evolution of the roles and titles of doctor, surgeon and physician reflects a rich tapestry of medical history shaped by societal structures, scientific advancements and cultural traditions. These titles not only highlight professional distinctions but also carry intriguing stories, including the peculiar tradition of surgeons being addressed as Mr. or Ms., in some countries and the origins of the barber pole symbol.

The Rise of Doctors and Physicians

The word doctor originates from the Latin docere, meaning "to teach." In medieval Europe, this title was reserved for scholars with the highest academic degrees in theology, law or medicine. Physicians, specifically, were university-trained professionals who practised internal medicine, diagnosing and treating ailments based on theories like the humors. Their academic standing granted them the title 'Doctor', a marker of intellectual authority.

The term physician itself derives from the Greek physikos, meaning "natural." Physicians in antiquity, like Hippocrates and Galen, viewed medicine as a branch of natural philosophy. They avoided manual labour, which they considered beneath their scholarly status, focusing instead on theoretical and diagnostic aspects of care.

The Evolution of Surgeons

Surgeons took a very different path. The word surgeon comes from the Greek cheirourgos (hand-worker), reflecting the practical, manual nature of their work. In medieval Europe, surgery was often performed by barber-surgeons, who combined grooming services with basic medical care such as bloodletting, tooth extraction and wound treatment. These barber-surgeons were not university-trained and thus did not hold the title 'Doctor'. Instead, they were addressed as 'Mister' (or its equivalent).

The barber pole, now a symbol of barbers, traces its origin to these early barber-surgeons. The pole's red and white stripes represent blood and bandages, while the spiral design reflects the twisting motion of the tourniquet used during bloodletting. A blue stripe is sometimes added in modern versions, often interpreted as symbolising veins.

A Shift in Status

By the Renaissance, advances in anatomy and surgical techniques, championed by figures like Ambroise Paré, began elevating surgery's status. Professional colleges, such as the Royal College of Surgeons in London, formalised surgical training in the 18th and 19th centuries. Surgeons began earning the respect once reserved for physicians, yet they retained the 'Mister' title after passing their surgical exams as a nod to their distinct heritage and professional identity.

Convergence in Modern Medicine

Today, while surgeons in many countries are called 'Doctor', those in the UK and parts of the Commonwealth maintain the 'Mister' (or equivalent) title as a badge of honour reflecting their historical craft. This tradition serves as a reminder of the diverse origins of the medical profession, where scholars, craftsmen and healers united to advance the art and science of medicine. The barber pole, now a relic of the past, further highlights the fascinating journey of surgery from its humble beginnings to a respected scientific discipline.

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CASE CHALLENGE

8-year-old girl was brought in with c/o severe abdominal pain and an evolving rash, as shown in Photos 1-2. There was no purpura or bleeding from anywhere.

Blood work – Normal

Ultrasound Abdomen- Normal



Photo 1

Photo 2

**What's your
spot diagnosis?**

(For Answer: Please refer to the last page)

**Compiled by
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Sampoorna Swasthya Sanwardhan (संपूर्ण स्वास्थ्य संवर्धन)

In this section, we share a short article on Child Psychology, Mental Health and Wellness, Neuroscience, Emotional Intelligence & Effective Parenting for Holistic Health of Children



Cultivating 'Emotional Vocabulary' In Children - The Key To Raising An Emotionally Intelligent Child

Dr Sandeep M Kelkar

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MRR Children's Hospital

Kids can feel all of the same tricky, wonderful, sometimes confusing and even intense emotions that we adults do. It's important for them to know that it's okay to feel all of their emotions- good ones as well as uncomfortable ones.

Children should get the message that all emotions are important because they tell us a lot about ourselves and the world around us. They also help us connect with one another. Learning how to notice, label and express their feelings helps children feel more in control.

How to teach all these basic Emotional Literacy skills to children?

Start With This

- When kids talk about their feelings, caregivers should make sure they feel heard. Let kids know that it's normal to have all kinds of feelings. Talking it through helps kids understand their feelings better and better as they grow.
- Talk about your own emotions and what they look and feel like. When kids do the same, give them praise to remind them that this is an important skill.

Practice Skills

Feelings Check-In

Check-in with your child every day and ask what they are feeling. Showing them pictures or giving them different words to use can help them get better at talking about their feelings — do this before jumping to problem-solving or fixing what is wrong!

You might say:

"I see that you're feeling sad and that's okay."

"I hear you feel angry and sad at the same time. That happens."

"It makes sense to feel excited and nervous!"

Give Feedback

Praise them every time they name their feelings or notice someone else's feelings. And be specific about what they did well. You might say: "Great job knowing that you feel scared. Thank you for letting me know."

"Good job noticing that you are feeling angry (mad). I will take deep breaths with you to calm down our bodies."

Use Picture Books and Stories

Ask kids how a character may be feeling based on the story or their expression in the picture. You can also use books and stories to help your child understand their own feelings and where in their body different feelings happen.



For example:

"How do you think Janhavi is feeling in this picture?" "What is Janhavi doing that makes you think she is feeling angry (mad)?" "Where do you feel mad in your body?"

Share how you are feeling and how you feel it in your body. This is a great way to teach kids that uncomfortable feelings are normal.





Overwhelmed

How I might feel when I'm overwhelmed
I want to squeeze my eyes shut,
cover my ears and make it all
go away

Things that might make me overwhelmed

1. When I'm in a very noisy place
2. When we visit friends and there are too many people



Surprised

How I might feel when I'm surprised
I'm happy and I might want to
say "Wow!"

Things that might make me surprised

1. When I get a gift and it's not even my birthday
2. When my Dad comes home with a new pet



Feelings Check-In

How Are You Feeling Today?



Frustrated



Embarrassed



Sad



Mad

**This
is
how
I
feel
today!**



Nervous



Happy



Proud



Scared



Loved



Lonely



HOSPITAL HIGHLIGHTS AND SUCCESS STORIES



We organised a Basic Life Support and First Aid Training Session at the Indian Institute of Management, Powai. Our Nurse Educator, Ms Rekha Patil, provided insightful guidance and led interactive demonstrations. Here are a few highlights from the session.





HOSPITAL HIGHLIGHTS AND SUCCESS STORIES



Tiddlee Preschool in association with MRR Children's Hospital organised a health check-up camp dedicated to promoting healthier futures for little ones! Our team of experts conducted health assessments, supporting the well-being of every child.

Take a look at some moments from the event!





HOSPITAL HIGHLIGHTS AND SUCCESS STORIES





HOSPITAL HIGHLIGHTS AND SUCCESS STORIES



International Day Of Radiology is observed every year on November 8. This day honours the discovery of X-rays and the incredible work of radiologists. At our paediatric hospital, we celebrate these dedicated professionals who play a vital role in healthcare.

Happy International Day Of Radiology!



INTERNATIONAL DAY OF RADIOLOGY

Celebrating the vital roles of radiologists
and radiographers in healthcare



HOSPITAL HIGHLIGHTS AND SUCCESS STORIES





HOSPITAL HIGHLIGHTS AND SUCCESS STORIES





HOSPITAL HIGHLIGHTS AND SUCCESS STORIES





HOSPITAL HIGHLIGHTS AND SUCCESS STORIES



This World Prematurity Day on 23rd Nov, we at MRR Children's Hospital hosted a series of insightful workshops designed to support and empower parents of preemies.

Led by Dr. Kiran More (Head Of NICU) and our dedicated team of NICU doctors, the sessions provided invaluable guidance on caring for premature babies.





HOSPITAL HIGHLIGHTS AND SUCCESS STORIES





HOSPITAL HIGHLIGHTS AND SUCCESS STORIES



We were thrilled to welcome the students from various schools for our unique and engaging **Children's Day event "Tare Zameen Par: An Out-of-this-world Experience"** – an Artificial Planetarium Show.



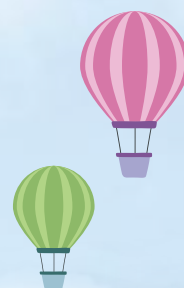


HOSPITAL HIGHLIGHTS AND SUCCESS STORIES





• **Open 24x7**



MRR Children's Hospital

Where Children Come First

**A STATE-OF-THE-ART
SUPER SPECIALITY PAEDIATRIC HOSPITAL**



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CASE CHALLENGE

DIAGNOSIS: Urticaria Multiforme

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