This article reviews the most common skin disorders seen in children and outlines an approach to their management.

By Girish Patel, MB BS, MRCP and Caroline Mills, MB BS, FRCP

Skin diseases in childhood are common and the prevalence of conditions, such as atopic eczema, is increasing. Most childhood skin disease is diagnosed by general practitioners who will refer the more difficult cases to the local dermatologist or paediatrician. However, many parents will seek advice initially from a pharmacist.

Neonatal skin

The skin of a newborn baby differs from adult skin in several ways and, therefore, requires special consideration. It takes one month for the skin of a full-term infant to develop its barrier function and even longer in premature babies. These
differences mean that neonates are at increased risk of skin damage, cutaneous infection and toxicity from topically applied agents. Potential topical hazards include topical antiseptics (e.g., hexachlorophene and povidone iodine), as well as products containing boric acid, salicylic acid, urea, corticosteroids, neomycin and tar-containing products.1

nappy rash

There are at least four different patterns of napkin dermatitis, although advances in nappy design have reduced the incidence of severe, irritant cases

Napkin dermatitis

The advances in nappy design have led to a reduction in severe, irritant napkin dermatitis. There are at least four different patterns of napkin dermatitis, although there is overlap between these patterns. Recognition of the different types will help management. The four types of napkin rash are:

- Irritant dermatitis
- Candidiasis
- Seborrheic dermatitis
- Psoriasis

Irritant dermatitis Irritant dermatitis is the most common type of nappy rash. The skin will withstand reasonable exposure to the alkaline mixture of urine and faeces held in close proximity by a nappy. However, an abrasive nappy and the use of occlusive rubber or plastic pants will exacerbate the assault. Irritant dermatitis is caused by the action of faecal proteases on the skin. This effect is enhanced by the alkaline urinary pH.2 The eruption is associated with redness and scaling, although it may weep if severe or if there is a secondary infection. The rash is most prominent on the buttocks, the area most in contact with the irritants, and is less likely to be found in the skin creases. If skin irritation continues, the rash may become more generalised and chronic exposure can cause nodules, erosions and ulcers. It is interesting that in children with atopic eczema, the napkin area is often not affected while the child is wearing nappies.

Candidiasis Candidiasis is often suspected as being the cause of napkin dermatitis. Candida is often present if the affected skin is swabbed but it remains unclear if it has a pathogenic role. Candidiasis is an opportunistic infection in damaged skin and is secondary to irritant napkin dermatitis. It usually presents as a “collarette” of shallow pustules of 1 to 2mm in diameter around the circumference of the lesion, which enlarges outwards.

Seborrhoeic dermatitis Seborrhoeic dermatitis starts in the creases, sparing the convex surfaces. It presents as a rash, which is bright red and confluent. However, scaling, which is usually a prominent feature of dermatitis on other areas of the body, is absent in the napkin area. Infants may have a similar rash on the scalp, face and other flexures.

Psoriasis Psoriasis limited to the napkin area can occur. The eruption has a dull erythema with an absence of scaling. Typical red plaques with well-defined borders and silvery scales may be seen on the peripheries. Only 10 to 15 per cent of affected cases progress on to develop adulthood psoriasis. Whatever the cause of napkin dermatitis, reducing skin irritation from the nappy and its contents will facilitate treatment. It is important to explain to parents that coarse towelling can abrade the skin and smoother materials should be used. Where possible, quality, disposable nappies should be used as they are specially designed to soak up urine and maintain a dry skin/nappy interface.3 Nappies of any type must be changed frequently and rubber or plastic pants are best avoided. Whenever possible, the infant should be left for periods without any covering at all and a barrier ointment (see Panel 1) applied after each nappy change may be helpful. The use of small amounts of 1 per cent hydrocortisone ointment, applied for periods of up to one week, may be required to settle an inflammation. Nystatin, clotrimazole, econazole and miconazole-containing products can help if candida is present. Powder preparations should be avoided, as they can also act as a skin irritant.

Panel 1: Barrier creams suitable for napkin dermatitis

Zinc-containing

- Zinc cream BP
- Zinc and castor oil ointment BP
- Zinc ointment BP
- Sudocrem
- Vasogen

Titanium-containing
Common viral warts

Up to 20 per cent of school children have a viral wart on their hands or feet at any one time. Common warts are a superficial skin infection with human papilloma virus, two-thirds of which will spontaneously resolve within two years. Despite their benign nature, the presence of common warts is a frequent cause of concern. Unfortunately, there are no specific antiviral treatments that are effective against them. Currently available treatments aim to destroy the superficial skin cells harbouring the virus. Destructive therapies, such as freezing (cryotherapy) that cause pain are clearly inappropriate for use in children, especially as paint-on anti-wart treatments have similar efficacy.

We believe that treatment should be limited to over-the-counter (OTC) topical wart treatments, a view shared by many other dermatologists. Salicylic acid (11 to 50 per cent) preparations destroy superficial skin cells by causing them to separate away from each other. Response to treatment varies, with studies showing clearance rates of between 67 and 84 per cent after three months of daily treatment. Therapeutic efficacy can be improved by occlusion after application of the wart paint. Formaldehyde (0.75 per cent) and glutaraldehyde (10 per cent) can achieve up to 70 to 80 per cent eradication after three months of daily application. Ointments containing podophyllum resin (20 per cent) can be used on resistant plantar warts for limited periods only. However, topical treatment for warts with podophyllum resin has been associated with teratogenicity, peripheral neuropathy, confusional states, coma and even death but this is rare.

Extra care must be taken to ensure that this toxic treatment is not ingested accidentally.

Nut allergy

It is important, in patients with nut allergy, to avoid prescriptions containing nuts or nut products, for example, arachis oil and Hydromol cream. Nut allergy is an increasingly recognised problem, particularly in children. While it has been known for decades, it is clear that the proportion of children affected has increased dramatically in recent years. Its importance lies in the fact that, on rare occasions, it can cause anaphylaxis. Some children and adults who are allergic to one kind of nut may also become allergic to other kinds. These include peanuts, almonds, brazil nuts, cashew nuts, hazelnuts, pistachio nuts, walnuts and pecan nuts and, in fewer people, coconut, sesame seed, poppy seed, sunflower seed, green beans and pine kernels.

Molluscum contagiosum

Molluscum contagiosum is a common childhood infection, caused by the *Molluscum contagiosum* virus. It appears as small, pearly-white, hemispherical papules with a central pore, which can arise anywhere on the body. Molluscum contagiosum is managed by expressing the contents of the lesions. An inflammatory reaction develops around all the lesions after squeezing, picking, or sometimes spontaneously after several months, and they resolve. Treatment is not usually necessary but, occasionally, a spot may get a surrounding bacterial infection and benefit from treatment with a topical antibiotic.

Impetigo

Impetigo still remains an extremely common infection of infants and children, although it can affect all age groups. The infection is caused by a bacterium, *Staphylococcus aureus*. Impetigo presents as a characteristic weeping, golden, crusted eruption on an erythematous base, usually affecting the face. The golden crust is highly contagious, containing numerous bacteria. Infection is passed by direct contact with the lesion or through contaminated clothes or towels. Mild cases may respond to topical antibiotic preparations containing bacitracin, polymyxin, gramicidin or erythromycin. When treated with oral antibiotics and local bathing, the lesions of impetigo should clear within a week. Failure to wash away the crust is a common cause of relapse. As impetigo is easily transmitted, the child should not go to school or nursery until the lesions are clear. Impetigo may be associated with a worsening of eczema (discussed below) and rarely the development of staphylococcal scalded skin syndrome.
syndrome (SSSS). SSSS is a life-threatening dermatosis, which is caused by the systemic effects of an exotoxin secreted by the bacteria. It presents as an extremely tender red area, in which the superficial layer of the skin peels away, like skin that has been scalded. This begins in the flexures, neck, axillae and groin. SSSS is a clear indication for urgent dermatological referral.

Scabies

_Sarcopotes scabiei_ is a member of the arachnid family of arthropods and descriptions of scabies infestations date back to the earliest records of civilisation. Epidemics of scabies are believed to occur in 30-year cycles, each lasting 15 years. However, it appears that the current pandemic is persisting longer than 15 years.\(^\text{12}\) Infestation begins with a newly fertilised female mite being transmitted by close contact to a new host. The mite then tunnels into the uppermost layer of the skin where it lays its eggs. The severe itching associated with scabies takes four to six weeks to develop and patients often develop an allergic eczematous rash in response to the mite and to mite faeces.\(^\text{13}\) The subsequent eruption is a distinctive clinical syndrome of itchy papules, nodules and linear burrows. In adults and older children, the lesions tend to involve the finger webs, axillae, flexures of the arms, belt line and genitalia. In fact, red papules on scrotal skin are a diagnostic give-away. The distribution of lesions in infants and young children is slightly different, affecting the palms, soles, upper trunk, head, neck and face. Usually, the appearance is associated with secondary changes of eczema, evidence of scratching and crusting that can be caused by a secondary bacterial infection.

The diagnosis of scabies is made from a history of itching, the characteristic distribution of lesions, recognition of burrows and a similar rash and symptoms among family and other close contacts. The clinical diagnosis can be confirmed by taking a scraping from suspicious lesions and examining it under a microscope.

To eradicate the infestation, the whole family and close contacts must be treated simultaneously. Treatments for scabies are permethrin cream 5 per cent (Lyclear dermal cream) or malathion 0.5 per cent in aqueous base (Derbac, Quellada M, Prioderm lotion). Benzyl benzoate 25 per cent emulsion is not a suitable treatment for children because it is associated with skin irritation and requires multiple applications. Gamma benzene hexachloride (Lindane) has been withdrawn because of drug resistance and potential neurotoxicity in children.

Permethrin cream 5 per cent or malathion 0.5 per cent need to be applied to the whole body, with the exception of the head and neck, if the patient is over two years old, paying particular attention to the finger and toe webs. If the patient is under two years of age, treatment should also be applied to the head and neck. The treatment is washed off after a minimum of 12 hours with permethrin 5 per cent and 24 hours with malathion 0.5 per cent; at which time the bedding and clothing should be washed in hot water above 40°C.\(^\text{14}\)

Head lice

Head lice infestations are increasing in prevalence in the UK and as many as one in five children are affected in some schools.\(^\text{5}\) Head lice affect girls more than boys, probably because they have longer hair. In addition, older children have heavier infestations than younger ones. Head lice infestation causes itching of the scalp but no other ill effect and the lice do not carry additional diseases. The cutaneous lesions caused by feeding tend not to become infected but may be associated with an eczematous rash. Although combing the hair with a "nit comb" is conventionally regarded as an effective treatment, this does not seem to be the case. An epidemiological study of over 1,000 school children found that nit combs may lessen the severity of the infestation but were ineffective as method of treatment.\(^\text{16}\) The reason for this is not known.

Treatment with malathion (Derbac, Prioderm) is usually effective. Malathion has to be sprinkled over the scalp and is then rubbed in until the scalp is moistened. It is washed off after 12 hours. Care must be taken, as some products contain alcohol and are, therefore, flammable. A second treatment after seven days is necessary to treat any newly-hatched nits. Many pediculicides, particularly the older ones, are associated with drug resistance.
Head lice lesions may be associated with an eczematous rash

**Tinea capitis (scalp ringworm)**

Tinea capitis is still a common problem of pre-pubertal children, particularly among the immigrant population. Infected areas of the scalp usually present as red, round or oval patches, with hair loss and scaling. Infection in this country is usually with a zoophilic species, such as *Microsporum canis*. Zoophilic species are usually caught from pets, particularly cats. They typically cause a marked inflammatory response, particularly if transmitted by a non-domestic animal, with a raised red, boggy lesion. Infected hairs are fragile and, therefore, there is usually alopecia at the site of infection. If the fungus infects the outer hair shaft (an ectothrix infection, as in the case of M canis) it will fluoresce under UV light (Woods light). There has been a notable increase in *Trichophyton tonsurans*, an anthropophilic species (ie, humans are the host) in the UK. This is usually more prevalent in African countries. Anthropophilic dermatophytes can be passed from human to human and an animal vector is not required. In children with tinea capitis caused by an anthropophilic species, careful investigation of the outbreak is needed and the child should be excluded from school. However, in the case of infections caused by zoophilic species, children can normally be allowed to remain at school, as transmission from human to human is unlikely. There are regional variations in the cause of Tinea capitis within the UK and it is important that these are considered when the diagnosis is made. For children under 12 years of age, tinea capitis readily responds to oral griseofulvin 20mg/kg/day for up to six weeks. The newer systemic antifungals are not licensed for this indication. Although topical therapy is ineffective against tinea capitis, concomitant twice-weekly shampooing with selenium sulphide 2.5 per cent shampoo (Selsun) or ketoconazole shampoo (Nizoral) may suppress viable spores and thus limit spread.

**Tinea corporis (body ringworm)**

It is important not to miss the diagnosis of superficial tinea infection of the non hair-bearing skin (tinea corporis). It usually presents as a scaly, circular lesion on the face, trunk or limb. Spread is usually by direct contact with the infected host - human or animal. Tinea corporis responds readily to topical terbinafine cream, which can lead to resolution of the disease within two to four weeks. Children with tinea corporis should be encouraged to attend school but it may be worth preventing the child from playing sports in which there may be close physical contact.

Scalp ringworm (Tinea capitis) usually presents as red, round or oval patches, with hair loss and scaling

Tinea corporis is usually spread by direct contact with an infected host (human or animal)

**Athlete’s foot**

In children, athlete’s foot from tinea alone is uncommon. The cause is usually multifactorial and includes Candida, erythrasma, bacterial infection and poor hygiene. In most instances, advice about simple foot hygiene should suffice. This includes washing the feet daily, drying between the toes, wearing cotton and not nylon socks and non-occlusive footwear. Absorbent powders containing undecylenic acid, miconazole or tolnaftate can be helpful, as can antiperspirants, such as salicylic acid 3 to 6 per cent in alcohol or aluminium chloride.

**Atopic eczema**

Atopic eczema is associated with significant psychological and physical burden for the patient, family and siblings. The prevalence of atopy and atopic eczema is increasing. Atopic eczema probably arises from a combination of genetic and environmental factors.
Patients complain of dryness of the skin and itching. The itching becomes more marked when there is associated erythema, weeping and crusting. There is often infection, usually with S. aureus, which can exacerbate eczema. Thus, antibacterial treatment is often a useful adjunct to eczema treatment.

The distribution of the eruption changes with age. During infancy, it predominantly involves the face, but during childhood eczema tends to affect limb flexures.

Treatment is aimed at disease control and symptom relief. The goals of therapy include decreasing itch, which in turn reduces sleep loss and allows the child to attend school and participate fully. It is the clinician’s duty to balance effective control of the condition against the use of safe, long-term therapy. Involving and educating the child and family about their condition and its management is essential in achieving these objectives.

The main trigger for eczema is dryness of the skin. In the management of all patients with eczema, the central focus should be the prevention of skin dryness with the routine use of emollients (see Panel 2).

Emollients may take the form of soap-substitutes and bath oils, or be applied directly to the skin. They reduce the dryness and inflammation that is associated with eczema and represent the backbone of eczema therapy. Soap-substitutes and bath emollients aim to prevent water from damaging the skin and provide an emollient covering. Although bathing once daily with bath oil is advised, prolonged exposure to water and the use of cosmetic bath additives (eg, bubble bath) are irritant to the skin. Shower emollients are available for those patients who prefer to shower.

Topical emollient should be applied after bathing to prevent evaporative water-loss and should then be applied throughout the day to prevent drying of the skin. Topical emollients can be divided into those that are greasy (lipophilic) - usually ointments - and lighter (less lipophilic) creams. Greasy emollients are preferable but these may not always be acceptable to the patient. The addition of urea can enhance the effect of lighter emollients. Theoretically, the addition of antiseptics to emollients should reduce S. aureus carriage and have an additive benefit.

For any emollients to be effective, the patient needs to have a clear understanding of their importance in the management of eczema. Emollient preparations have to be appealing to the patient - it is pointless prescribing an emollient that will just be left on the bathroom shelf. Topical corticosteroids are the mainstay treatment for atopic eczema and can be divided into four potencies - mild, moderately potent, potent and very potent. Children rarely require treatment with anything more than mild or moderately potent corticosteroids. Preparations should be applied twice daily to the inflamed skin, at least 30 minutes before the application of an emollient. Topical corticosteroids must continue to be applied to an affected area for at least five days after any inflammation has settled, to prevent a rebound of the eczema.

There is a tendency to under-prescribe the amount of topical treatment required and Longe et al. have developed a practical approach to topical therapy using “fingertip units” as measures of the quantity of cream or ointment to use. One fingertip unit is the amount of cream that covers the area from the end of the finger to the distal interphalangeal joint. This is equivalent to about 0.5g or the surface area of two palms. The number of grams of steroid cream required to cover the body can, therefore, be measured in fingertip units, where necessary (see Table 1).

Table 1: Amount of topical steroid treatment required for twice daily application (g)

<table>
<thead>
<tr>
<th>Age</th>
<th>Daily requirement</th>
<th>Weekly requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months</td>
<td>8</td>
<td>56</td>
</tr>
<tr>
<td>6 months</td>
<td>9.5</td>
<td>66.5</td>
</tr>
<tr>
<td>12 months</td>
<td>12</td>
<td>84</td>
</tr>
<tr>
<td>18 months</td>
<td>13.25</td>
<td>92.75</td>
</tr>
<tr>
<td>2 years</td>
<td>13.5</td>
<td>94.5</td>
</tr>
<tr>
<td>3 years</td>
<td>16</td>
<td>112</td>
</tr>
<tr>
<td>4 years</td>
<td>19.25</td>
<td>134.75</td>
</tr>
<tr>
<td>5 years</td>
<td>20</td>
<td>140</td>
</tr>
<tr>
<td>7 years</td>
<td>24.5</td>
<td>171.5</td>
</tr>
<tr>
<td>10 years</td>
<td>30</td>
<td>210</td>
</tr>
<tr>
<td>12 years</td>
<td>36.5</td>
<td>255.5</td>
</tr>
</tbody>
</table>

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The amount of treatment necessary to cover a given body site changes with age. For example, to treat a five-year-old from head to toe would require 140g of topical steroid and at least 280g of emollient per week. It is better to use adequate amounts of therapy that treat the eruption than to have prolonged ineffectual therapy.

Occasionally, bandages have to be applied to the skin to enhance the emollient effect and provide an occlusive barrier against scratching. Various methods of “wrapping” have been developed, including Tubifast, Ichthopaste and Viscopaste bandages. These bandages can be very effective but care must be taken, as they also enhance the penetration of topical corticosteroids.
### Panel 2: Prescription emollients

**Topical**

<table>
<thead>
<tr>
<th>Less greasy emollient</th>
<th>Bath</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoderm</td>
<td>Alcoderm</td>
</tr>
<tr>
<td>Aqueous cream</td>
<td>Alpha keri bath</td>
</tr>
<tr>
<td>Aveeno</td>
<td>Aveeno</td>
</tr>
<tr>
<td>Dermamist</td>
<td>Balneum</td>
</tr>
<tr>
<td>Diprobate</td>
<td>Balneum plus</td>
</tr>
<tr>
<td>E45 cream</td>
<td>Diprobath</td>
</tr>
<tr>
<td>Humiderm</td>
<td>E45</td>
</tr>
<tr>
<td>Hydromol cream</td>
<td>Emmolate</td>
</tr>
<tr>
<td>Hydrous ointment</td>
<td>Eurax</td>
</tr>
<tr>
<td>Kamillosaan</td>
<td>Hydromol</td>
</tr>
<tr>
<td>Keri</td>
<td>Imuder therapeutic oil</td>
</tr>
<tr>
<td>Lacticare</td>
<td>Infaderm therapeutic oil</td>
</tr>
<tr>
<td>Morhulin</td>
<td>Oilatum</td>
</tr>
<tr>
<td>Neutrogena dermatology cream</td>
<td>With antiseptic</td>
</tr>
<tr>
<td>Oilatum</td>
<td>Dermol 600</td>
</tr>
<tr>
<td>Unguentum M</td>
<td>Emulsiderm</td>
</tr>
<tr>
<td>Vaseline dermacare</td>
<td>Oilatum plus</td>
</tr>
</tbody>
</table>

**Greasy emollient**

<table>
<thead>
<tr>
<th>Emulsifying ointment</th>
<th>Soap substitutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emulsifying ointment</td>
<td>Alcoderm</td>
</tr>
<tr>
<td>Epaderm</td>
<td>Aqueous cream</td>
</tr>
<tr>
<td>Hewletts cream</td>
<td>E 45 wash</td>
</tr>
<tr>
<td>Ultrabase</td>
<td>Epaderm</td>
</tr>
<tr>
<td>Lipobase</td>
<td>Emulsifying ointment</td>
</tr>
<tr>
<td>White soft paraffin</td>
<td>Ultrabase</td>
</tr>
<tr>
<td>White soft paraffin and liquid paraffin mix</td>
<td>With urea</td>
</tr>
<tr>
<td>Aquadrade</td>
<td></td>
</tr>
<tr>
<td>Balneum</td>
<td></td>
</tr>
<tr>
<td>Calmurid</td>
<td></td>
</tr>
<tr>
<td>Eucerin</td>
<td></td>
</tr>
<tr>
<td>Nutraplus</td>
<td></td>
</tr>
<tr>
<td>With antiseptic</td>
<td></td>
</tr>
<tr>
<td>Dermol 500</td>
<td></td>
</tr>
</tbody>
</table>

**Shower emollient**

<table>
<thead>
<tr>
<th>Without antiseptic</th>
<th>With antiseptic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oilatum</td>
<td>Dermol 200</td>
</tr>
</tbody>
</table>

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Dr Patel is specialist registrar, department of dermatology, University Hospital of Wales, Cardiff. Dr Mills is consultant dermatologist, department of dermatology, Royal Gwent hospital, Newport

Credit for Learning: 2

This article forms the basis of questions under the PJ/College of Pharmacy Practice Credit for Learning scheme.[see p169](#)

References

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This is one of common childhood diseases and disorders that are caused by bacteria. This is considered the third most common skin disease in kids. Impetigo happens in kids at the ages of two to six years. It is contagious and even adults can have this skin problem, too. People will get skin itchiness and sores on various parts of the body. To cure impetigo, people can use different prescription antibiotic drugs that can eliminate impetigo fast. Then, people can avoid scars on skin. 11. Dental Caries. I always welcome all your feedbacks about this article of 18 common childhood diseases, conditions and disorders. Do you see your child get another disease? Tell me and I would like to recommend you proven tips and methods to improve your child’s health.