Welcome to this edition of Pediatric Pulse, a Kentucky Children’s Hospital newsletter published specifically for referring physicians. In this newsletter we provide updates on the happenings at Kentucky Children’s Hospital in addition to information about new or interesting services we offer.

In the last issue, I mentioned that the KCH renovation continues. This issue includes an update on the progress, including some photos and illustrations. Also in this issue, Dr. Robert Broughton discusses the prevention and treatment of tick-transmitted infections which becomes more prevalent now that our weather is getting warmer and kids increasingly spend their time outside. Our pediatric surgeons, Drs. Iocono, Draus and Skinner explain when a pediatric surgical specialist is needed. You also will find information on emergency preparedness and simulation training that is available to your practice as well as announcements and updates in our recurring columns.

I realize that there have been difficulties referring patients to certain specialties. We are aware of those frustrations and are working hard to recruit the appropriate staff to help alleviate those issues. Thank you for your understanding.

Kentucky Children’s Hospital records now are available through the physician portal. The most utilized information is the online discharge notes from the newborn nursery and units, along with lab results and procedural notes. More daily progress notes also are being made available online. Our liaisons will be glad to instruct you or your office staff in accessing the portal.

As always, we are continuing to focus on improving communication with our referring providers. In the meantime, if you have trouble getting in touch with your patient’s attending physician, please contact me through UK•MDs (toll free 800-888-5533), email at cwall4@uky.edu, or my office phone 859-323-1432.

Carmel Wallace, MD
Physician-in-Chief,
Kentucky Children’s Hospital
Chair, Department of Pediatrics
Division Chief, General Academic Pediatrics

To refer a patient, please call UK•MDs at 800-888-5533.

If there is a topic you would like addressed in our next quarterly issue, please contact Tarra Crane Lowe at 859-257-5736 or tlcran2@email.uky.edu.
Recognition and prevention of tick transmitted infections in Kentucky

Robert A. Broughton, M.D.
Chief, Division of Pediatric Infectious Disease

As spring has (finally) arrived and thoughts turn to spring flowers and horse racing, primary care providers caring for children in Kentucky should remember that tick transmitted infections may be seen more frequently. Our division fields many questions and sees patients who are referred to us for consideration of tick-borne illness. This article will review the clinical recognition, diagnosis and management of the major tick-borne diseases seen in Kentucky and the recommendations for avoiding tick bites and removing attached ticks.

Rocky Mountain Spotted Fever (RMSF) is the most common recognized tick-borne illness in Kentucky, with 72 confirmed or probable cases reported to the state’s epidemiology division in 2013. The illness occurs primarily in children, but also in adults, with the principal vector being the dog tick. Following an incubation period of two and 14 days, it classically presents initially with high fever, headache and myalgias, followed usually by a rash two to five days later. The rash, which occurs in more than 90 percent of children but less often in adults, may be macular, maculopapular and/or petechial or even purpuric. It typically begins on the wrists, forearms and ankles and then spreads centrally; involvement of the palms and soles occurs in 50 to 80 percent of patients. Nonspecific laboratory findings include thrombocytopenia, anemia, leukopenia with lymphopenia, thrombocytopenia, elevated liver enzymes and hyponatremia; proteinuria, hematuria, azotemia and CSF abnormalities may occasionally be seen. The diagnosis is confirmed either through specific serology (4-fold rise in IgG antibody and detection of IgM antibody by immunofluorescent assay (IFA) or enzyme immunoassay (ELA)) or detection of nucleic acid in peripheral blood by polymerase chain reaction (PCR). Doxycycline is the drug of choice for treatment in all age groups. It should be started when the diagnosis is strongly suspected even before laboratory confirmation is obtained and is usually continued for between seven and 14 (at least 3 days after defervescence).

Tularemia is reported in about one to five patients per year in Kentucky. The reservoir for the causative organism, Francisella tularensis, includes more than 100 species of wild animals (particularly rabbits, voles, muskrats and beavers), some domestic animals (including cats, sheep and cattle), blood sucking arthropods that bite these animals (ticks, deer flies, mosquitos), and water and soil contaminated by infected animals. Human infection is usually acquired from direct contact with infected animals, via ingestion of contaminated water or inadequately cooked meat, via inhalation of contaminated particles, or via the bite of an arthropod vector, particularly ticks. It is estimated that between 50 and 75 percent of human infections are acquired from ticks. Although several tularemic syndromes exist, the most common (75 percent) is the ulceroglandular form, characterized by development of a maculopapular lesion at the site of entry (usually a tick bite) after a usual incubation period of between three and five days, with subsequent ulceration and associated tender, enlarged regional lymphadenopathy. In children, the tick bite and ulcer is most commonly seen in the scalp, and there is associated occipital and/or...
posterior cervical lymphadenopathy; fever, chills, myalgias, arthralgias and headache may also occur. The second most common syndrome is glandular disease, characterized by regional lymphadenopathy without an associated ulcer. The diagnosis is usually confirmed serologically by the rise of agglutinating antibody over a few weeks’ time; no specific IgM assay is available. Some laboratories may be able to identify the organism by PCR or direct fluorescent antibody (DFA) assays in ulcer exudate or material obtained from aspirating an infected lymph node. Although the aminoglycosides gentamicin or streptomycin are recommended for treatment of severe disease, ciprofloxacin or doxycycline are alternative agents for mild disease; if doxycycline is used, therapy should be continued for at least 14 days since its use may be accompanied by a higher rate of relapse.

Lyme disease is a spirochetal illness caused by *Borrelia burgdorferi* and transmitted to humans primarily by bites of ticks of the genus *Ixodes*. The most common vector-borne disease in the U.S., it occurs primarily in three geographic regions in the U.S. (the southern New England and eastern mid-Atlantic states, the upper Midwest and the northern West Coast). Lyme disease is relatively rare in Kentucky, and only 37 probable or confirmed cases were reported in Kentucky in 2013. Almost all of these were reported from Western Kentucky and only four were reported in children 19 or younger. In the past 30 years, the author is aware of only two patients with confirmed Lyme disease seen in consultation by our division. *Ixodes* ticks are relatively rare in Kentucky and, in contrast to *Ixodes* ticks found in the northeast US, they feed on reptiles, whose blood is bacteriostatic against *B burgdorferi*, rather than small mammals. Patients from nonendemic areas who are reported to have Lyme disease have often acquired the infection in states with endemic disease or may have false positive serologic test results. Manifestations of Lyme disease are divided into early localized disease, early disseminated disease and late disseminated disease. Early localized disease, the most common manifestation in children, is characterized by the distinctive rash, erythema migrans (EM). This usually develops one to two weeks after the tick bite at the site of the bite and begins as an erythematous macule or papule that usually expands over days to weeks to form a large (larger than 5 centimeters) annular erythematous lesion that is usually, but not always, painless and non-pruritic. Partial central clearing is sometimes seen; vesicular, ulcerative, necrotic areas in the center are also observed. Erythema migrans is often accompanied by fever, malaise, headache, arthralgias, myalgias and neck stiffness. Only about 20 percent of children with Lyme disease present for medical attention with early disseminated disease. This most commonly manifests as multiple EM, usually developing three to five weeks after the tick bite, and consist of secondary annular erythematous lesions similar to but smaller than the original lesion; these reflect spirochetemia with dermal dissemination. Other rarer manifestations of early disseminated disease may occur without a history of EM and include cranial nerve palsies (especially facial nerve palsy), lymphocytic meningitis, ophthalmologic conditions (conjunctivitis, keratitis, uveitis, optic neuritis), and, very rarely in children, carditis (usually presenting as various degrees of heart block). Late disseminated disease presents most commonly as arthritis, with onset from five to six weeks up to two years after the tick bite and no history of preceding EM in about 50 percent of patients. It is usually monoarticular or pauciarticular, is occasionally migratory, and has a predilection for the large joints, especially the knees. Central nervous system manifestations and peripheral neuropathy are much less commonly seen manifestations of late infection. The diagnosis of early localized Lyme disease is usually established clinically, by recognition of EM; antibodies to the organism are usually not found in the first four weeks of infection and antibiotic therapy of early disease may abort the development of an antibody response later. The diagnosis of early disseminated infection when multiple EM lesions are present is also usually made clinically. Diagnosis of early disseminated disease in patients without a rash or late disseminated disease is made on the basis of clinical manifestations and serology. Serologic confirmation is done by a two-step process, with an initial test for serum antibodies performed by enzyme immunoassay (EIA) or immunofluorescent assay (IFA). If this testing is negative, no further testing is indicated. If the initial screening test is positive or equivocal/indeterminate, Western immunoblot analysis should be performed. This assay is less sensitive
for detecting antibodies to the organism than EIA or IFA; thus, it should not be performed unless the EIA or IFA is positive or equivocal/indeterminate. However, immunoblot is more specific for detecting antibodies to the organism than EIA or IFA so it is used to distinguish a false positive EIA or IFA from true infection. For patients with suspected early disseminated disease, both the IgG and IgM immunoblot assay should be done; for patients with suspected late disseminated disease, only the IgG immunoblot should be done as false positives may occur with the IgM immunoblot in that population. Positive result of the IgG immunoblot requires detection of antibody (bands) to 5 or more polypeptides; positive result of the IgM immunoblot requires detection of antibody (bands) to at least 2 polypeptides. Other serologic tests have been developed and are under investigation but are not yet recommended for routine use; one assay, the C6 assay, may be less sensitive than the recommended two-step protocol. Once antibodies develop, they may persist for life, so repeat antibody assays are not useful in assessing the success of therapy. Serologic tests should not be performed in patients with non-specific symptoms such as arthralgias and fatigue; almost all positive serologic tests in those patients are false positives. Non-specific symptoms may accompany objective signs of infection but are almost never the only evidence of infection. Polymerase chain reaction (PCR) may be used to detect DNA of B burgdorferi in joint fluid and CSF, but is not recommended for testing of blood. Identification of the organism by culture is not available commercially and is not recommended. Recommended antimicrobial therapy of Lyme disease is dependent on the stage of disease and manifestation. Treatment of early localized disease, when EM is present, almost always prevents progression of the disease to later stages. Oral doxycycline is the drug of choice for children 8 years or older, with amoxicillin recommended for those younger than 8; therapy should be continued for 14-21 days. For early and late disseminated disease, doxycycline or amoxicillin (depending on the patient’s age as noted above) is recommended for 14-21 days for patients with isolated facial nerve palsy or asymptomatic carditis, for 21 days for patients with multiple EM, and for 28 days for those with arthritis. Patients with persistent or recurrent arthritis may be retreated with the same oral regimen as used earlier for 28 days OR parenteral ceftriaxone, cefotaxime, or penicillin for 14-28 days. Patients with symptomatic carditis should be treated with parenteral ceftriaxone or penicillin for 14-21 days. Those with meningitis are usually treated with parenteral ceftriaxone, cefotaxime, or penicillin for 14 days (range 10-28 days), although some evidence suggests that oral doxycycline for a similar duration is also effective; those with encephalitis or other late neurologic disease are usually treated with parenteral ceftriaxone, cefotaxime, or penicillin for 14-28 days.

A tick-borne illness that produces a skin lesion indistinguishable from erythema migrans (EM) is Southern tick-associated rash illness (STARI). This illness, whose etiology has not yet been conclusively identified but is likely a spirochete related to B burgdorferi, is primarily seen in the southeast and south central regions of the US, areas where Lyme disease is rarely seen, although some cases have been reported from the mid-Atlantic states (Maryland, Delaware, New Jersey) where Lyme disease more often occurs. The rash follows the bite of the lone star tick, a tick which is found in Kentucky. The EM rash may be accompanied by mild systemic symptoms such as fatigue, nausea, headache, and myalgias, but, in contrast to Lyme disease, STARI is not associated with later complications. There is no diagnostic test, so the illness is diagnosed clinically based on compatible signs and symptoms in an individual with a history of a tick bite in a known endemic area for the lone star tick. There have been no randomized, controlled trials of therapy for the disease, but patients with suspected STARI have usually responded promptly to therapy with doxycycline.

Prevention of tick-borne diseases centers on trying to avoid tick bites and removing attached ticks as soon as possible.

Recommendations for avoiding tick bites include: (1) Avoid tick-infested areas when possible; (2) Walk in the center of trails so vegetation does not brush against the skin; (3) Wear light-colored clothing that covers, as much as feasible, exposed areas of skin. Permethrin can be sprayed onto clothes (but not skin) to decrease tick attachment, or wear clothing pre-treated with permethrin. Tuck long pants into socks and boots and button long-sleeved shirts at the cuff; (4) For children 2 months of age or older, use insect repellent that contains 20-30% DEET on exposed skin; (5) After possible tick exposure, inspect the clothing and body for ticks at least daily. Direct special attention to areas where ticks frequently attach (scalp, neck, axillae, groin, belt line, legs, between toes, behind ears); (6) Check pets who spend time outdoors for ticks and remove them; also use pet tick prevention medication.

To remove an attached tick, it is preferable to grasp the tick with fine-point tweezers as close to the skin as possible and, gently but firmly, pull it straight out without jerking or twisting the tick. Although not recommended, if fingers are used to remove the tick, they should be protected with use of tissue or gloves and washed after the procedure. The bite site should be washed with soap and water to decrease the
risk of secondary bacterial infection.

Antibiotic prophylaxis after a tick bite is not usually recommended. The only exception may be when an individual 8 years or older has been bitten in an area with hyperendemic Lyme disease (not Kentucky) and an engorged deer tick is found attached to the skin, especially if the suspected duration of attachment is 36 hours or more and if prophylaxis can be administered within 72 hours after the tick was removed. On the basis of one study, single dose doxycycline may be beneficial in this situation; insufficient data are available regarding amoxicillin prophylaxis.

To refer a patient, contact UK•MDs at 800-888-5533.

Dr. Jackie Noonan named “Gifted Educator” for 2014

Dr. Jacqueline (Jackie) Noonan, long-time faculty member at the University of Kentucky College of Medicine and former chair of the Department of Pediatrics, has been named the “Gifted Educator” for 2014 by the American College of Cardiology.

The award recognizes an educator who has demonstrated innovative, outstanding teaching characteristics that contribute significantly to the field of cardiovascular medicine.

Noonan came to UK’s newly established College of Medicine in 1961. In 1963, she began publishing papers about children with a rare type of heart defect and distinct physical characteristics. The condition was eventually named Noonan Syndrome in acknowledgment of her efforts.

This is not the first time Noonan has been recognized for her work. She was given the Helen B. Fraser Award from the Kentucky Public Health Association, named one of the Best Women Doctors in America by Harper’s Bazaar, and received a Lifetime Achievement Award from The Best Doctors in America. She also received the A. Bradley Soule Award from The University of Vermont, her alma mater.

Noonan accepted her award at the ACC annual meeting on March 31 in Washington, D.C.

UK HealthCare pediatricians publish comprehensive textbook on newborn kidney disease

UK HealthCare pediatricians Aftab Chishti, MD, and Stefan Kiessling, MD, have authored a new textbook that provides in-depth clinical instruction about the treatment of kidney and urinary tract disease in newborns.

Published in January, “Kidney and Urinary Tract Disease in Newborns,” provides doctors with comprehensive, practical instruction for the diagnosis and treatment of kidney diseases in babies younger than 1 year old. The text includes insight from more than 20 contributors who are experts in the field of pediatric nephrology. Topics addressed in the book include high blood pressure, urinary tract disease, hypertension, cystic kidney disease, urological abnormalities, kidney failure, nutrition for children with kidney disease and kidney function. Each chapter of the text ends with a clinical case example and take-home messages for practical application.

To purchase a copy visit: http://www.springer.com/medicine/nephrology/book/978-3-642-39987-9

Outreach Corner

Practice Emergency Preparedness with Medical Simulation

Michael Wittkamp, MD, FAAP
Pediatric Critical Care

The problem with emergencies is that they tend to be rare events. As such, keeping up essential skills for dealing with these situations can be challenge. This is especially true within medicine.

Enter medical simulation. The University of Kentucky and Kentucky Children’s Hospital have a wonderful high-fidelity medical simulation program on campus, but now we are prepared to bring it to our colleagues in the community. As simulator technology now allows for easy portability, we are happy to offer in-office medical emergency simulation training for area practices. We can help you practice skills and coordination that may need a little dusting off. Please contact Dr. Michael Wittkamp, one of the Kentucky Children’s Hospital Critical Care Attendings and co-director of the KCH Medical Simulation Education Program, to arrange an opportunity for you and your practice. Email him at michael.wittkamp@uky.edu
Pediatric surgical specialists –
What are they? When does a child need to see one? Are they close by?

At least once a week, someone approaches one of us in a social situation and asks about a particular problem their child is having and the question commonly asked is, “Do they need to see a specialist?” This article helps define what it means to be a specialist in children’s care and discusses the need to be proactive when a child needs care from a specialist. In this ever-changing and complex world of medicine and surgery, it’s important to make sure every member of a child’s care team is pediatric-focused. We believe that seeing a pediatric specialist, when available, is optimal care for children.

General considerations

Whether you realize it or not, most parents already use specialists when it comes to the most basic aspects of their child’s care. Pediatricians are specialists in the care of children, and family practitioners are specialists in the care of a family. Parents wouldn’t ask their cardiologist questions about immunizations for their baby. You should know that there are choices and, for the most part, these choices are available locally. We are fortunate that right here in Lexington, Kentucky Children’s Hospital has assembled a team of specialists in areas of infant and pediatric surgical care.

What is a specialist?

Any time someone develops a condition that is beyond the scope of a primary caregiver, a patient is referred to a physician who has limited their practice to treating a subset of diseases. This person is a specialist. Cardiologists, pulmonologists and orthopedic surgeons are all examples of specialty doctors. What people don’t often realize is that for every adult specialty, there exists a corresponding pediatric specialist who treats subsets of diseases only in infants and children. It is interesting when children need specialty care, such as evaluations by a lung specialist, heart specialist or surgeon, that they are commonly referred to adult specialists who “see children in their practice.” Indeed, there are examples when this is appropriate but parents need to be informed health care consumers and know that a dedicated pediatric specialist sees only infants and children and knows the unique aspects of taking care of little ones. When told that your child needs to see a specialist, as a parent, you need to stay informed and ask your primary care physician “Is there a pediatric specialist available to see my child for this?” Are they available locally? Have they completed additional specialized training in the care of children? Are they available locally?

Care as a team

When discussing the unique aspects of infant and childhood diseases, we commonly employ the phrase, “children are not little adults.” The most important thing to remember is the same exact symptoms in an adult and a child may lead to a totally different diagnosis, and any specialist needs to be keyed into these differences.

Another often forgotten aspect of specialty care in children is the “team concept” of care. For example, when an infant presents for a surgical consultation at Kentucky Children’s Hospital, the child will be seen by a physician who has had extra training in their surgical specialty for infants and children. Our surgical care team includes specialists in plastic surgery, otolaryngology (ENT), kidney transplantation, advanced minimally invasive surgery, trauma surgery, neonatal surgery, cancer surgery, urologic surgery and even gynecology all here in Lexington at Kentucky Children’s Hospital. We also have pediatric medical specialists in every major discipline to help care for your entire child. Each of these physicians has completed a fellowship to learn about specific surgical issues in children.

Now, if a decision for surgery is made, the infant is then evaluated by an anesthesiologist who also has special training in the unique aspects of putting that infant to sleep. Later, after admission to the hospital for recovery after surgery, the nurses at KCH are indeed dedicated pediatric nurses. Special facilities at KCH include the region’s only pediatric intensive care unit, a level IV neonatal intensive care unit, a level I pediatric trauma center, the Makenna David Pediatric Emergency room and a pediatric specific sedation suite. Our pediatric intensive care unit is the only one in the area if your child needs this sophisticated care. There is access to child life specialists whose only job is
Pediatric Pulse

UK HealthCare is pleased to announce the arrival of
Leslie Appiah, MD 
Oncofertility
Pediatric & Adolescent Gynecology

Leslie A. Appiah, MD, joins UK HealthCare as a board-certified gynecologist with expertise in oncofertility and fellowship training in pediatric and adolescent gynecology. Dr. Appiah brings five years of experience from Cincinnati Children’s Hospital Medical Center, where she served as director of oncofertility and fellowship director of pediatric and adolescent gynecology.

Dr. Appiah will serve as director of oncofertility at UK. She will work closely with subspecialists in reproductive endocrinology and infertility at the Markey Cancer Center and Kentucky Children’s Hospital. Dr. Appiah and her team will collaborate to preserve the fertility and reproductive health of pediatric, adolescent and adult cancer and blood disorder patients of all genders.

Dr. Appiah attended medical school at the University of Texas Southwestern Medical Center at Dallas. She completed her residency in OB-GYN at Sinai Hospital of Baltimore and a clinical fellowship in pediatric and adolescent gynecology at Texas Children’s Hospital. She has received several teaching awards including the Johns Hopkins Excellence in Teaching Award.

Dr. Appiah’s interests include fertility preservation, minimally invasive surgery, congenital anomalies of the reproductive tract, hormone replacement therapy and endometriosis.

Conclusion

Hearing that a child needs to see a specialist will bring obvious anxiety to any parent. Understanding that they are going to see a specialist who cares for their “little ones” will help to ease this anxiety and helps to provide optimum care for the child. Knowing this care is close to home provides an added layer of comfort.

The Division of Pediatric Surgery at Kentucky Children’s Hospital is just one of our groups of surgical specialists at KCH. The office number is 859-323-5625, extension 9.

Renovation focused on themes of home and away

Seth Flynn
Development Communications

Kentucky Children’s Hospital is embarking on an exciting adventure that will transform the current inpatient spaces into destinations that resemble “home” with various uniquely Kentucky connections and “away” with plenty of far-off, exotic locales. Based on themes of water, sky and land, various destinations will allow children to transport themselves to a place that will enable their imaginations to run wild, but at the same time, remain close to home as they receive care at Kentucky’s Children’s Hospital.

In its initial phase of renovation, two spaces of Kentucky Children’s were transformed to coincide with home and away theme. It is through the support of generous two organizations, Log A Load for Kids/Kentucky Forestry Industries Association and The Makenna Foundation, that brought new life was infused into signature areas of KCH patient care facility: child life play room and welcome center, respectively.

Meet Our New Physician

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Preventing falls

Unintentional falls continue to be the leading cause of non-fatal injury for children; 43 percent of fall-related injuries are among children 4 and under.

Falls prevention checklist

**Install window guards and stops:**
- Screens are meant to keep bugs out, not children in.
- Install window stops so that windows open no more than four inches.
- Keep windows locked and closed when not in use.
- Move chairs, cribs and other furniture away from windows.

**Keep safety in mind while shopping:**
- Never leave a child unattended in a shopping cart.
- Use the harness or safety belt provided.
- Allowing a child to ride in the cart basket, on the sides, or on the front of the cart is very dangerous.

**Secure kids when seated:**
- Keep little ones strapped in when using high chairs, infant carriers, swings and strollers.
- Place infant carriers on the floor, not on top of a table or other furniture.

**Help babies learn to stand and walk safely:**
- Use a stationary activity center instead of a baby walker. Look for one that is on a stable, non-moveable base and place it away from stairs, hot appliances or window cords.

**Watch out for the stairs:**
- Use approved safety gates at the tops and bottoms of stairs and secure according to manufacturer’s instructions.
- Actively supervise toddlers on stairs.

**Play on soft surfaces at playgrounds**
- Take kids to playgrounds with shock-absorbing surfaces such as rubber.
- Talk to kids about appropriate play behaviors.

**Be smart, protect your head**
- Teach children to always wear the appropriate helmet.
- Adults are role-models; wear your helmet.

**Prevent slips at home**
- Consider anti-slip rugs and mats or decals in the bathtub or shower.
- Keep hallways and stairs well-lighted and clear of clutter.
- Secure TVs and furniture to the wall to prevent tip-overs.

Follow us on Facebook at www.facebook.com/pages/Safe-Kids-Fayette-County/91901343364