

Camp Doctoring

Howard Owens MD, CCFP(EM), FCFP

The experience I bring;

Emergency physician and some FP years ago, parent of two girls, went to camp/worked at camp growing up

9 years of camp doc experience at Walden, assisted with some of their infirmary policies and procedures

Differences between camp and ER/city office;

Like any rural practice decisions are more difficult as ordering an xray may commit staff member to hours of driving/being away from camp, turn around on Blood work takes days, sending a kid to the ER or home has major implications to kid, parents, camp

Advantages are like those of caring for your own kids – if you live with/near them you don't have to make a decision NOW, you can observe a kid with fever/abd pain/minor injury for hours/days to see how they are doing, reassess anytime.

Today, another advantage is that with an Internet connection a world of resources are always available.

My approach was always that I was mostly acting “in loco parentis” giving some aid/comfort and mostly encouragement- “you'll be OK!” (and some hugs if needed).

Avoid a disaster at all costs – so if you are truly worried, send them out

Special care with kids with underlying disease – check medical forms and ask the kids (some parents very irresponsible re; forms, but kids know something- or their siblings)

Antennae for secondary gain, sick role kids (visitors day – like mother/father like child);

Check records/nursing staff re; frequency of infirmary visits

Ask camp staff re; secondary gain (avoid swimming, canoe trips) and figure out what the avoidance is related to

Frequent fliers – just like office/ER, gaining +ve attention from captive peer group – focus on attention NOT dependent on symptoms, shift/channel toward normal camp involvement, set some limits - give them some positive attention not dependent on being sick

Watch for collusion among kids – epidemic of "broken" braces one year as kids discovered it was good for a free ticket home over changeover.

Special problems;

Lice, everyone relax, lice just a nuisance! Try to prevent at entry with careful screen, even imperfect approach will decrease active infestation and relieve symptoms, for girls with long, light coloured hair may be impossible to cure until they get home. Promising new approach for camp is single dose oral treatment with Ivermectin.

Gastro – food/water – point onset, everyone gets sick with a few hours of each other versus Norwalk-like – spread in waves over days/week

Food water = public health problem, probably need outside help, viral is a nuisance for all but kids with underlying illness so relax, wash hands

Strep throat- again concern is exaggerated. Treatment only benefit is preventing rheumatic fever which is exceedingly rare! A clinical approach is favoured using the "McIsaac" strep throat score;

- fever = 1 point
- exudate or pus on tonsils = 1 point
- tender, enlarged anterior cervical lymph nodes = 1 point
- absence of cough = 1 point

A score of 3 or 4 - treat with AB's. A score of less than 3, probably viral, treat with fluids, gargles, popsicles or ice, offer analgesia including codeine for older kids and adults.

Most stings and rashes respond to ice or cold compresses, calamine lotion, and an oral antihistamine if bad. Can add topical steroids for rashes but avoid using them on the face. However, if widespread, severely itchy, consider a short course of oral prednisone at high doses (50 mg/ day for full size kids/adults) for 3-5 days. Will work wonders for those really suffering.

Impetigo more crusted than allergic reactions. Look for problems with hygiene. Start off treating topically with sterile cleansing and topical AB's, but if spreading or presents widespread treat orally.

Get out and have some fun with the kids!

H. Ovens May, 2010

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