

Ask the pediatrician: Is polio a serious concern again?

By **YVONNE A. MALDONADO**

American Academy of Pediatrics

Q: I've read about polio appearing again in the U.S. Should I be worried about my kids?

A: It was reported over the summer that an unvaccinated man in New York got polio and has developed paralysis, and there is evidence of the virus circulating in the state's wastewater. The patient reportedly contracted a form of polio that can be traced back to the live poliovirus used in the oral vaccine. This version of the vaccine has not been used in the U.S. since 2000. Health officials said the virus probably originated overseas in an oral vaccine distributed there.

People who are vaccinated should not be concerned, but for those who are unvaccinated, this is a red flag.

We have not seen polio in the

United States since the 1970s and '80s, and polio was declared eliminated from the Western Hemisphere in 1994. We know the polio vaccine works.

Polio is caused by a virus that affects infants and young children more often than other age groups. Most cases of polio are mild. Paralytic polio causes muscles to be paralyzed, leaving some people physically impaired for the rest of their lives.

Before the polio vaccine, widespread cases of paralytic polio in the U.S. led many parents to be worried about letting their children swim in public pools or gather at movie theaters or parks.

Since the mid-1950s, the polio vaccines have led to a dramatic decline — with over a 99% reduction in polio cases around the world. The “natural” or “wild” type of poliovirus that infected children decades ago is eliminated from the U.S. and

much of the rest of the world.

Polio can spread to other people through contact with stool (poop) from an infected person or droplets from a sneeze or cough. It is transmitted from contact with fecal matter (stool or poop) within one to two weeks after a person is infected with polio. A person who gets stool or droplets from an infected person on their hands will get infected if they touch their mouth. Children who are not vaccinated can get infected if they put toys or other objects that have stool or droplets on them in their mouth.

An infected person can spread poliovirus to others before they have symptoms. The virus can live in an infected person's stool for weeks. People can contaminate food and water if they touch it with unwashed hands.

It is hard to detect polio or prevent it from spreading. Chil-

dren who are not immunized are at risk. Most people with polio infection will have no symptoms. Infrequently, polio can cause paralysis in the arms and legs or even death if muscles involved in breathing are paralyzed.

Symptoms may begin with a low-grade fever and a sore throat about six to 20 days after being exposed to the virus. Children also may feel pain or stiffness in their back, neck and legs for a brief time. Paralysis causes severe muscle pain.

A person is most contagious seven to 10 days before symptoms occur and can infect others for another seven to 10 days. No treatment is available for polio. Some children fully recover from polio, but others are disabled for a lifetime or may die from the disease.

The best protection is the polio vaccine. In the United States, the inactivated polio vac-

cine is the only vaccine recommended. IPV is given as a shot by trained health workers.

Most people in the United States have been vaccinated against polio and are at very low risk for polio infection and paralysis. People who have not been vaccinated or who have not received all doses of polio vaccine are at higher risk if they are exposed to someone who is infected with polio or someone who received the oral polio vaccine.

Stay up to date on all your children's vaccines, some of which may have been overlooked during the pandemic. Talk to your pediatrician if you have any questions or concerns.

■ *Dr. Yvonne A. Maldonado is the chief of the Division of Pediatric Infectious Diseases at the Stanford University School of Medicine. For more information, go to HealthyChildren.org, the website for parents from the AAP.*

Should you get your flu shot and COVID booster together?

By **LISA M. KRIEGER**

The Mercury News

The flu shot is as familiar an October ritual as football, foliage and Halloween.

But health officials are urging Americans to get the new flu shot and COVID booster at the same time — the sooner, the better.

“Right where we are now — that's a good time to be vaccinated,” influenza expert Dr. Lisa Grohskopf of the U.S. Centers for Disease Control and Prevention told the nation's physicians in a conference call late last week.

That's ahead of time, by traditional measures. Flu season most often peaks in February — and our levels of protective antibodies are at their highest about two weeks after the shot, then wane over the next four to six months.

Yet this year's season could start early if it follows the pattern seen elsewhere in the world. So a delay could catch people unprepared.

There's another concern: People may not want to make two trips to the vaccination clinic — so they may get the new COVID booster but fail to return for the flu.

Is there a perfect time to be vaccinated?

If you have a crystal ball, “it's 14 days before the flu attacks the community that you're living in,” said Dr. Darwin Scott Smith, clinical lead for flu vaccination at Kaiser Permanente Northern California, who has already gotten his shot.

Here's the problem:



A sign directing traffic to a drive-through flu shot station.

Seth Herald/Getty Images-TNS, File

Nobody knows when that will be.

Nearly four decades of CDC data shows that 45% of flu seasons peak in February.

But 18% of the time, the season peaks as early as December. In another 16%, it peaks as late as March. Protection isn't assured until two weeks after your shot.

“It is impossible to predict the flu season with any accuracy,” said Dr. Kelly L. Moore, president of Immunize.org, a nonprofit group that works to increase immunization rates.

If you want to save time and travel, said Moore, get your flu shot when you get the new COVID booster, now widely available at California's pharmacies and clinics. It's safe and will spare you a return trip. There's no data to show that

side effects will be worse.

A flu shot won't protect against COVID, and a COVID shot won't protect against flu. The two vaccines are very different.

“I really believe this is why God gave us two arms — one for the flu shot and the other one for the COVID shot,” White House COVID coordinator Dr. Ashish Jha said at a Sept. 6 news briefing.

Children who need two doses of the flu vaccine — those six months through 8 years who have never been vaccinated — should receive their first dose immediately, said experts.

A September shot will create antibodies that can persist long enough to help fend off a later infection, experts said. And even if they don't, you'll get less seriously ill than if you weren't vaccinated at all.

“I'm going to try to get my flu vaccine at the earliest opportunity,” said Dr. Bali Pulendran, professor of immunology at Stanford University School of Medicine.

“Even if the durability of the antibody response is just a few months, I should be good throughout the season,” he said.

September also offers a practical advantage: It's easier to get an appointment. Everyone won't all be rushing in at once, as could happen once the virus arrives.

October is the optimal time from an immunological perspective, experts said. Like all cells, antibodies die of old age. A Kaiser study found a 16% increase in the odds of catching the flu every additional 28 days after peak protection.

That's especially true for older adults, who experience a greater waning of protection than younger people.

“Just don't forget,” said Moore. “When the opportunity arises, get it.”

If you're not vaccinated by October, it's not too late. Vaccines help as long as flu viruses are circulating.

Once spring comes, you may be worried about protection. But don't get a second flu vaccine, said Smith.

Forecasting a flu season is always a challenge. It can vary in different parts of the country. Every year is different.

Because COVID has changed our behaviors, “the old rules — what we knew about when flu starts, when it ends — may not work this year,” said UCSC infectious disease expert Dr. Peter Chin-Hong, who aims to get his shot in mid-October.

“I wouldn't game the system,” he said. “If the flu has a slow burn, you'll want it before it peaks.”

There are three reasons to be cautious, said Smith.

Based on this year's experience in the Southern Hemisphere, flu season could come early. U.S. health officials look to Australian trends for guidance — and cases there started in April instead of the usual June.

It also was a worse season than the two previous years when people were masked and distancing, said Kaiser's Smith. Behaviors have changed. People are going out more.

Finally, we have less overall immunity to the flu because we've been sitting it out for two years, with lower vaccination rates and reduced exposure to the flu virus.

Last year, flu season was mild but ran long. Experts were surprised by a second small peak, with cases jumping in April and May.

Infectious disease trends “are all whacked out,” said Chin-Hong. It's not just flu — the timing of the common respiratory syncytial virus (RSV), monkeypox and other pathogens have proved startling, he said.

To be sure, flu vaccines are far from perfect. CDC data shows that efficacy ranges widely from year to year, falling to 19% in 2014-15 and climbing to 52% in 2013-14. This year's vaccines are “quadrivalent,” meaning they target four different strains of the flu virus; of these, two are different from last year's shot.

Circulating viruses may also genetically drift over time, so a vaccine that is well matched in September may be mismatched in March.

Scientists are now striving to build a better flu vaccine, so it's less critical to time shots perfectly, said Pulendran.

The biggest worry now is not whether the shots are perfectly scheduled — but that people will skip the vaccines altogether, or just forget, said Moore.

“If you sit down at the Thanksgiving table with someone who is sick,” she said, “it's too late.”

On Nutrition: What to do with leftovers before they go bad

By **BARBARA INTERMILL**

Tribune News Service

I am aware that some people, for one reason or another, do not eat leftovers. That would not be our household, even before these days of high food prices.

It's estimated that we Americans waste 30% to 40% of the food we purchase. That equates to 219 pounds of groceries that each of us tosses in the garbage every year, according to the Environmental Protection Agency. And two-thirds of that food is a fruit, vegetable or dairy product that ends up in a landfill instead of nourishing a body with essential nutrients.

What can we do when vegetables go bad before we eat them? Eat them before they go bad. ... duh.



Lucidwaters-TNS

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Many foods can also be frozen for future use. I really don't like overripe bananas. So I freeze them, three to a bag, and they're ready for my next batch of banana bread. Onions and droopy celery can also be chopped and frozen for use in soups and

other dishes.

We call our clean-out-the-refrigerator meals “conglomerates.” Last week, for example, I chopped and sliced the incredible tomatoes and zucchini our gracious neighbors had left on our porch.

I cooked them with a leftover half-onion and kernels shucked from the last of the sweet corn we got from our farmer friend. Oh, and that little Tupperware of leftover meat and green chile from my enchiladas a few days ago? That went into the mix, too. A few seasonings to boot, and we had a meal that took me right back to my native New Mexican roots.

Some leftovers can be a challenge. I used to cringe each time I'd open a whole can of tomato paste when the recipe called for just one tablespoon. I never seemed to use the rest before it devel-

oped creepy mold.

Then I learned leftover tomato paste can be frozen in individual portions with the help of plastic wrap and a freezer-proof container. Now I just need to remember it's in the freezer.

On a larger scale, many organizations recover fresh, edible food no longer needed by restaurants, grocers and other food establishments and distribute them to people in need.

Local food banks such as feedingamerica.org or foodbanking.org, as well as programs like Food Rescue US (foodrescue.us), use volun-

teers to redistribute surplus food to food-insecure people on a daily basis. That's encouraging.

No one's perfect, however. The other day, I found a lost gem in the back of the fridge that had obviously been hidden for way too long. In this case, the old adage still holds true: If in doubt, throw it out.

■ *Barbara Intermill is a registered dietitian nutritionist and syndicated columnist. She is the author of “Quinn-Essential Nutrition: The Uncomplicated Science of Eating.” Email her at barbara@quinessentialnutrition.com.*

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